LECTURE NOTES ON
PSYCHIATRY

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SCIENTIFIC PUBLICATIONS
OXFORD

1956
10-6-66

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SCIENTIFIC PUBLICATIONS
OXFORD

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FIRST PUBLISHED 1964

S.C.E.R.T., West Bengal
Date 10.6.66
Acc. No. 1956

616.89
W1L

Printed and bound in Great Britain by

WILLMER BROTHERS AND HARAM LTD, BIRKENHEAD

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Acknowledgements

This book could not have been written without the encouragement of many former teachers and colleagues. Dr David Stafford-Clark was chief among these. Dr Colin McEvedy gave much valuable advice and Miss D. Harlow typed the manuscripts. The publishers, Mr Per Saugman particularly, have been extremely patient throughout and for this I am most grateful.

An Introduction to Psychiatry

Medical students often say that they find psychiatry interesting but disappointing. Interesting because psychiatry is a clinical subject and all students seem to like this, disappointing because as they frequently put it 'it all seems vague and woolly', also they are put off by the apparent lack of a sound body of psychiatric knowledge and the disagreements about diagnosis and treatment.

This book is not intended as a comprehensive text, the length and omissions should make that clear. It is written to try and answer the sort of questions that students seem to need answering fairly quickly when they start a psychiatry clerkship. They find themselves in difficulties because they have to learn a new language and acquire a new set of concepts of illness if they are to retain any interest in psychiatry at all. Too often they are discouraged from trying and emerge as doctors with blind spots for psychological illness.

Medical student training may be the subject of discussion, research and revision but the fact is that it does not equip students for the easy assimilation of psychiatric attitudes and ideas.

For a start the student finds that he needs to re-examine his own concept of disease. Up to now he has had no difficulty in seeing that patients with tumours, fractures, diabetes etc., are in diseased states. His psychiatric patient on the other hand often appears well and disclaims symptoms; no handicap is obvious until he finds that the patient's inner life is dominated by a series of fantastic beliefs which have caused him to alter his way of living so that he is now in hospital—maybe against his will. What does he make of that? Is he ill? Are there many patients like that and if so what is wrong with them?

Psychiatry deals with this sort of patient and many others; what they all have in common is disturbances affecting their behaviour, emotions, thinking and perception. This is the psychiatric frame of reference. We can set it down more formally by saying that we recognize psychiatric illness by examining the patient's

(1) behaviour,
(2) mood,
(3) perception,
(4) thought content,
(5) intelligence level,
(6) memory,
(7) concentration,
(8) orientation in space and time,
cognitive functions

and by discerning abnormalities make a clinical diagnosis.

The manifestations of psychiatric disorder can be recognized without great difficulty. The medical student's difficulty in examining psychiatric patients can usually be traced to:

(1) lack of method,
(2) lack of practice.

It is our intention in this work to provide a simple clinical guide to psychiatric language and syndromes.

The student should always remember:

(1) to listen carefully,
(2) to record conscientiously,
(3) to avoid interpreting and speculating about what he supposes the patient means,
(4) to get a history from as many informants as possible,
(5) only to use words that he understands.

CLASSIFICATION OF MENTAL ILLNESS

The ideal classification would be based on aetiology. In psychiatry this is rarely possible except in certain organic disorders (e.g. G.P.I., delirium tremens), so that classification tends to be descriptive, that is to say based on the dominant observable features of the syndrome (e.g. anxiety, depression). This is unsatisfactory but inevitable at present. The danger of the descriptive method lies in the possibility that the name given to a syndrome may assign to it a separate existence. For example we may talk about schizophrenia without assuming that there is a 'thing' schizophrenia. If the word is allowed to assume a concrete reality this stifles further enquiry.

Classification then may be unsatisfactory but necessary since we have to achieve some sort of order. Many systems are used, some are more satisfactory than others. In this work we will use this classification: it is clinical, oversimple no doubt, but adequate.

Schizophrenia	Simple Hebephrenic Catatonic Paranoid
Affective disorder	Depression Mania and hypomania Anxiety
Organic states	Delirium Dementia
Hysteria	Hysterical personality Conversion hysteria
Personality disorder	Abnormal personalities Psychopathy
Obsessional disorder	
Subnormality	
Severe subnormality	

CHAPTER 1

The History — Some Terms Defined — The Examination

The psychiatric history, like any other, is an attempt to set down an accurate account of an illness. It is taken in the usual way but the technique should be modified to permit the patient to tell his story without becoming unnecessarily distressed. Distress and misery are commonplace since so often the history refers to painful topics. The patient should be allowed to start off wherever he likes in the history rather than adhering to a rigid scheme of questioning—there should be time to sort out all the data afterwards.

THE FIRST INTERVIEW

One should attempt to take as full a history as possible on this occasion but it may not be a practical nor a humane possibility. This first interview is likely to be an event of great significance for the patient—he may have been dreading it or preparing himself for it for days and when it is over it is something he is likely to remember. With this in mind the doctor should do all he can to make the experience bearable for the patient and resist the temptation to question like a cross-examining attorney.

(a) How to elicit a history

Students often complain that they don't know what questions to ask the patient and are surprised when a more skilled examiner unearths facts they had missed. The answer to this difficulty is relatively simple. A history, after all, is only an edited series of answers to an elaborate questionnaire and with practice the expert learns what questions to ask, and constructs his own questionnaire. Listening to others taking a history illustrates this very well—

actually this is as good a way of learning to take a history as any, and not widely enough used.

(b) Symptoms and signs

Modes of presentation and symptomatology are of a different order in psychiatry, though not inevitably so. One patient complains of bodily symptoms, another brings a story of persecution by others, whilst another complains of altered mood and poor concentration. Many patients have no complaint at all and deny all symptoms, the history being given by relatives who tell a different story

(c) The relationship

The relationship between doctor and patient starts as the patient comes through the door. The patient's initial greeting may be friendly, hostile, suspicious or just neutral. Whatever it is the doctor stands to lose or gain a great deal by his own behaviour. There is no substitute for *friendly politeness* and no place for patronizing pseudo-omniscience. The patient should be accepted as he is and not subjected to value judgements. The talkative patient should be permitted to tell his story as he likes at first, and then be guided through the areas that the doctor wants to cover so that a comprehensive history can be taken. The reticent patient needs encouragement, and although this can be difficult, one must not put words in the patient's mouth.

THE PLACE OF HISTORY TAKING IN DIAGNOSIS

Diagnosis is made by examination of the mental state. The history contributes to our understanding of the mental state—it is a pointer to the diagnosis. History taking takes time. One cannot learn much about a patient in five minutes or even fifty, for that matter. There is no place in good psychiatry or good medical practice for the 'spot diagnosis'—in psychiatry it generally turns out to be no diagnosis at all.

A scheme for History Taking

A formal scheme has to be used for writing down the history. This does not mean that one has to take it down in the following order.

COMPLAINT

This should consist merely of a short statement of the patient's complaint, or if he has none, a short statement of the reason for his referral for psychiatric opinion.

FAMILY HISTORY

In this one should enumerate the *parents* and *siblings,* noting carefully such details as *ages, employment, illnesses, causes of death.* It should also include where possible some account of the incidence of any *familial psychiatric illnesses.* The family history too should give some information about the *social status* and *inter personal relationships* within the family.

PERSONAL HISTORY

This should commence with a note of the date and place of birth. Any information available about the patient's infant development should be recorded with particular reference to *health* during childhood, *neurotic symptoms* and *infant milestones. School record* should next be noted down, concentrating not only on the names of the schools and the leaving age etc., but attempting if possible to state the individual's attainments at school and estimate his social popularity etc. *Occupations* should next be considered in chronological order with wages earned and status. It is also useful to make some note of the individual's relationships with employers and colleagues.

MENSTRUAL AND PSYCHO-SEXUAL HISTORY

This includes the usual menstrual history with the addition of psycho-sexual topics such as how the patient acquired sexual information, his/her *varieties* and *frequency of sexual practice* and *fantasy.* The marital history should be noted with details of *engagement, marriage* and *pregnancies* and their outcome.

PAST ILLNESSES

Recorded chronologically.

PAST PSYCHIATRIC ILLNESSES

Recorded chronologically.

With details of any admissions and treatments received.

PRE-MORBID PERSONALITY

An attempt should be made to describe as accurately as possible the individual's personality before the illness. This is the part of the history that usually causes the greatest difficulty since our methods of describing the personality are so imperfect. In practice, the most helpful descriptions of the pre-morbid personality are not those which consist merely of one or two adjectives but rather those which give a portrait of the individual, consisting of a few paragraphs.

DESCRIPTION OF PRESENT ILLNESS

This should be a detailed chronological account of the illness from the onset to the present time.

THE PSYCHIATRIC EXAMINATION

The examination of the patient does not stop short at the examination of his mental state but includes a general physical examination, and where needed, physical investigation. Many individuals referred to a psychiatrist turn out to have either associated physical disease or else disease causing their altered mental state. Examples of the latter would be such conditions as cerebral tumours, general paresis, disseminated sclerosis and myxoedema. The physical examination too, has a positive value in the reassurance of a hypochondriacal patient.

PSYCHIATRIC LANGUAGE—A FEW TERMS DEFINED

Before going any further into details of how we examine and describe the mental state, here is a list of commonly used psychiatric terms.

Anxiety

A feeling of fear or apprehension commonly accompanied by autonomic disturbance. Anxiety may be felt by healthy subjects in the face of stress such as examinations etc., but is described as morbid anxiety when it pervades the mental life of an individual.

Depression

Pathological mood disturbance resembling sadness or grief. Depression is described as reactive when it can be related to an apparent causal agent, and endogenous when it appears out of the blue. The mood change is accompanied by characteristic disturbance of sleep, energy and thinking.

Dementia
Progressive, irreversible intellectual impairment. Dementia is caused by organic brain disease.

Delirium
An organic mental state in which altered consciousness is combined with psychomotor overactivity, hallucinosis and disorientation.

Depersonalization
A subjective feeling of altered reality of the self, e.g. 'I'm not myself any more. I feel as if I were dead; I feel unreal. Different to what I was. If only I could wake up.'

Derealization
A subjective feeling of altered reality of the environment, e.g. 'Everything around me seems strange like in a dream. Things don't look or feel the same,' usually associated with depersonalization.

Delusion
A false belief which is inappropriate to an individual's sociocultural background, and which is held in the face of logical argument. True delusions appear suddenly and are held with extraordinary conviction. Delusion is thus a primary experience in which incorrect judgements are made, e.g. 'I was walking along the street and saw a dog and immediately I knew by the way it stood that I was a special person predestined to save mankind.'

Ego, Superego and Id
Terms used by Freud in his theory of personality structure. The ego is conscious and concerned with reality while the superego is beyond consciousness and acts as a governor of ego activity. The Id is a reservoir of primitive instinct and drive.

Flight of ideas
Accelerated thinking, characteristically seen in hypomanic and manic illness. The association between ideas are casual, and are determined by such things as puns and rhymes. However links are detectable and the flight can be followed.

Hallucinations

A perception occurring in the absence of an outside stimulus (e.g. hearing a voice outside one). Hallucinations are particularly common in schizophrenia. Patients hear voices which tell them to do things, comment on their actions, utter obscenities or murmur wordlessly. The phenomenon of 'hearing one's thoughts spoken aloud' is encountered in schizophrenia. Hallucinations are described as hypnagogic if they are experienced whilst falling asleep and hypnopompic if experienced whilst waking up.

Hypochondriasis

Preoccupation with fancied illness. Hypochondriacal features are common in depression and may be found as bizarre phenomena in schizophrenia. Hypochondriasis may be the central feature of a hysterical illness. It seems likely that hypochondriasis does not exist on its own but is usually a manifestation of some underlying psychiatric condition or personality disorder.

Illusion

A perceptual error or misinterpretation. These commonly occur in organic mental states, particularly delirium. A patient in such a state misinterpreted a building outside his window as being a liner about to sail.

Ideas of reference

The patient who has ideas of reference experiences events and perceives objects in his environment as having a special significance for himself. For example a patient noticed that all the TV programmes she saw indicated to her in some unusual way that she had been singled out for observation by a secret police force.

Neurosis and Psychosis

These terms are widely used and lack precise definition. For general purposes it can be said that neuroses are states of less severe disturbance where anxiety is a prominent symptom and that neurotic patients do not lose contact with reality. In psychotic states contact with reality is lost and bizarre ideas are more common, as is gross behavioural disturbance.

Mannerism

A habitual expressive movement of the face or body. Normal mannerisms are appropriate but pathological mannerisms are inappropriate (e.g. in schizophrenia).

Obsessional phenomena (obsessive compulsive phenomena)
These are contents of consciousness of an unpleasant and recurrent sort which the patient experiences but which he resists. These contents may include words, ideas, phrases and acts. This is well exemplified by a patient who had to perform every act of washing, dressing and eating nine times or else he became anxious and distressed.

Paranoid
This is generally used to mean persecutory. Thus paranoid delusions are delusions of persecution.

Passivity feeling
A feeling of bodily influence or control by outside agents. Almost pathognomonic of schizophrenia.

Schizophrenia
A syndrome, occurring mainly in young people, in which are found characteristic disturbances of *thinking, perception, emotion* and *behaviour*. The illness tends to lead to disintegration of the personality.

Schizophrenic thought disorder
A characteristic type of disturbance of thinking, found only in schizophrenia, in which there is a basic disturbance of the process of conceptual thinking. This shows itself in the patient's speech, which reflects his impaired logical thinking. Early schizophrenic thought disorder often manifests itself as a subjective difficulty in thinking clearly. In its most severe form thought disorder reduces patients' talk to fragmented nonsense—'word salad'.

GENERAL ADVICE REGARDING THE EXAMINATION OF AND DESCRIPTION OF THE MENTAL STATE

The signs of mental disturbance can be elicited provided one learns how to do this, in much the same way that one learns to elicit physical signs in general medicine. However, one should avoid leading questions, and also it is important to avoid making remarks or comments to the patient which may implant in his mind disruptive or disturbing ideas. In this way one can avoid *interpreting* to the patient the *apparent meaning* of his experiences or feelings. Interpretation should be avoided and left to the expert. The patient should not be antagonized if he appears to be uncooperative. Antagonism, resistance and evasiveness can usually be overcome by handling the situation in a non-committal way. Recording the patient's talk verbatim is extremely useful but may antagonize a prickly patient. Here is a scheme for the mental state:

BEHAVIOUR

In describing the patient's behaviour one should try as far as possible to get an accurate description of how the patient behaves during interview. One starts by observing the patient's behaviour, instead of just taking it for granted. Points to note include:

(1) the patient's general level of consciousness,
(2) awareness of what is going on around him,
(3) his level of cooperation with the examiner,
(4) whether he is able to make contact with the examiner at interview,
(5) the patient's predominant facial expressions and whether they are appropriate,
(6) his use of gesture,
(7) activity—free or constrained, continuous or interrupted,
(8) the presence of agitation,
(9) use of mannerisms.

This is not a complete list but is only intended as a guide.

TALK

It is usual to consider both the *form* and the *content* of the patient's talk. The *form* is the manner of talk, i.e. how it presents, sustained, interrupted, fast or slow etc. The simplest way to examine the content of the patient's talk is by making a verbatim sample. Content means the predominant topics.

MOOD

Here we try to comment on whether the patient's mood is sustained or variable. What is the predominant mood as far as possible? Quite often a description of the patient's mood cannot be put down in one word, e.g. depressed. A useful way of enquiring about the patient's mood is to ask some question such as 'How do you feel in yourself?' or 'How are your spirits?'

THOUGHT CONTENT

(a) *Delusions.* These can only be elicited by careful questioning. Some patients will talk very spontaneously about their delusions and express a wide variety of illogical ideas. Other patients will need to be questioned. Paranoid delusions are delusions of persecution and to elicit them requires bland questions which do not arouse the patients suspicions too strongly. Such questions as 'Are people treating you as they should?' or 'How are people behaving towards you, do you suppose?' are often quite useful. Enquire about the patient's attitude to his own self. Ask whether he feels he has changed in any way, or whether he feels he is a good or bad person. This may help to elicit feelings of guilt and self-recrimination.

(b) *Hypochondriacal ideas.*
(c) *Obsessive compulsive phenomena.*

PERCEPTUAL DISTURBANCE

Here one records hallucinations and illusions, noting the modality of the hallucination and its content. Also the occasions on which they tend to occur.

COGNITIVE TESTING

(a) *Memory.* The patient's account of his history when compared with other informants will give some assessment of his memory for past events. Recent memory may be roughly tested by asking the patient to remember a name and address for five minutes and also by testing his ability to retain a series of digits.

(b) *Orientation.* Record the patient's account of the time of day, date and place.

(c) *Concentration.* One should record the patient's level of attention to the questions asked him and also try and test his concentrating ability by asking him to subtract 7 from 100 until he can go no further, noting the number of mistakes and the time taken.

GENERAL INFORMATION AND INTELLIGENCE

Under the heading 'General Information' one attempts to assess the individual's store of general knowledge. Useful questions here will include such things as the patient's familiarity with current affairs, topics of the day and familiarity with reigning figures and political names. Intelligence can be assessed quite roughly clinically bearing in mind the patient's educational background and professional attainments and some attempt should be made to place a patient on the scale:

(1) sub-normal,
(2) average,
(3) superior.

INSIGHT

Assessing the patient's insight is the most difficult thing of all. It does not merely mean asking the patient whether he knows whether he is ill or not although of course awareness of the existence of illness is an important criterion of insight. But in deciding and commenting upon the patient's level of insight, one wants to know too, how aware the patient is of the extent of his illness and its effect on other people, such as his family, employers, colleagues, etc. One wants to know too, whether the patient has any idea of how his illness seems to others or how he might feel about a similar illness in other people. Some idea about his insight might be gleaned from his views regarding future plans and so on.

SPECIAL INVESTIGATIONS

of the mental state include:

(a) Intelligence testing,
(b) Psychological tests designed to assess the personality.

The most commonly used intelligence tests are the Raven Progressive Matrices and Mill Hill Vocabulary Scale. These are tests of general and verbal ability, are well standardized, relatively simple to administer either to single patients or groups of patients and give a fairly accurate assessment of the individual's level of intelligence. The Wechsler Adult Intelligence Scale is a well standardized intelligence test which is more comprehensive than the former. It includes tests of Performance (picture completion, block design etc.) as well as Verbal tests. Personality tests fall into two main groups. The first are projective tests which are aimed at revealing unconscious processes, e.g. a patient is asked to describe what he sees in a pattern of ink blots (Rorschach) or to make up a story about an ambiguous picture (Thematic Apperception Test.)

The second type of test sets out to measure functions which correlate with personality types or neuroticism.

LABORATORY INVESTIGATIONS

There are no routine investigations in psychiatric practice, although chest X-ray, skull X-ray and Wasserman are probably the most commonly used. The investigator should have some good reason for wanting to have a particular investigation done, rather than resorting to whole batteries of special investigations.

Finally the essentials of history and mental state should be summarized in a formulation of the patient's illness, giving a 'bird's eye view' of the diagnosis, likely treatment and prognosis.

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CHAPTER 2

Anxiety

Anxiety is a universal phenomenon in which the subject experiences a feeling *akin to fear or apprehension* usually accompanied by autonomic disturbances (sympathetic overactivity), of which the following are typical:

(a) tachycardia and raised blood pressure,
(b) palpitations,
(c) dryness of mouth,
(d) diarrhoea, epigastric discomfort, nausea,
(e) dilated pupils,
(f) sweating,
(g) frequency of micturition.

Despite its universality, not all anxiety is pathological. It is useful to distinguish between *healthy* and *morbid* anxiety.

Healthy anxiety is experienced by most people under unaccustomed *stress*—examinations, interviews etc., being typical examples. It is a normal response to an unusual situation, an *adaptive response* on the part of the organism which prepares him for a task or ordeal requiring further effort and making unusual demands on him.

Morbid anxiety, however, is different; it is an *unadaptive response* and serves no useful purpose, once it is established—quite the opposite in fact! Too often it pervades the mental life of the individual and becomes a rein not a spur. The morbidly anxious patient is soon aware of the *paradoxical nature* of his affliction. Anxiety is experienced both in the presence of or the absence of what can be seen to be obvious stimuli. The patient knows that his fears are irrational and groundless but this is no help to him as he magnifies, scrutinizes and mulls over the content of his anxiety.

Aetiology

1. AGE

Anxiety is most common in adolescence and old age. *Adolescence* can be and often is a time of stress and turmoil. Young people are subject to all sorts of pressures at this time of their lives. Normal adolescent development is a period during which strong emotions are easily aroused—emotions which the subject finds hard to channel. He is at an 'in between' stage of life where he is accorded neither adult nor childish status. He is often oversensitive and prickly, particularly about his appearance which is more often than not gauche and pimply. It is hardly surprising then that emergent sexuality is tantalized by advertisements extolling the virtues of flawless skin or correct bust size. The adolescent is full of doubts about himself—will he get a job—the right sort of job? Will he get into a university? Is he going to be socially, sexually and in every other way competent when put to the test? All these sorts of questions are in his mind and it seems to him that everyone offers conflicting advice. In this setting he may develop *anxiety symptoms*, usually of an acute sort.

Old Age. Elderly people readily become anxious when the orderly routine of their life is threatened. Loneliness and the fear of death are also important causes of anxiety in old age.

2. CONSTITUTION

Some people are, by nature, more anxious than others. From early years and throughout their lives they are insecure, timid, and emotionally unstable. Their fears are easily aroused and they are over fussy about their health—tending readily towards hypochondriasis. Their *work records* are *poor*, and they show a *low level* of *drive, energy, ambition* and *persistence*. This combination of traits is regarded as evidence of *constitutional neuroticism* and the evidence for its existence has been convincingly demonstrated (Slater, Rees & Eysenck). Neuroticism correlates highly with physique, vasomotor instability and a background of poor general health.

3. LEARNING

There is much experimental evidence to suggest that where anxiety is linked to *specific stressors* (cats, open spaces etc.) the *phobia* as it is called, is a learnt phenomenon, i.e. has been developed by a process of simple conditioning and is subject to the same laws (generalization, inhibition, extinction etc.). This has been exploited therapeutically by using processes of *deconditioning* to extinguish *phobias* (see treatment).

Clinical Picture of Anxiety

In addition to experiencing the specific manifestations described at the beginning of this section, anxious patients often complain of feelings of *tension,* or of difficulty in *concentrating*. Tension manifests itself not only by a 'feeling of being strung up' but also by heaviness or pains in the limbs.

Associated *mood change of depressive type* is very commonly associated with anxiety—in fact a state of anxiety in pure culture is extremely rare—sooner or later depression appears.

Other bodily accompaniments of anxiety include decreased libido and impotence. Sleep is poor—typically the patient finds it hard to get off to sleep.

Diagnosis

Simple states of anxiety uncomplicated by depression are uncommon—most anxious patients have some depressive mood change. Anxiety may be prominent in the onset of a depressive illness. It is also not uncommon to find anxiety in the early stages of schizophrenia. Before deciding that a patient is suffering from simple anxiety one has to exclude:

(1) depression,
(2) schizophrenia.

However episodic attacks which can be confused with anxiety can be caused by:

(a) temporal lobe epilepsy,
(b) adrenalin secreting tumours,
(c) hypoglycaemia,

Treatment

A. PHYSICAL

(1) *Sedation*

Sedation, either with barbiturates or tranquillizers will relieve the symptoms of anxiety in the first instance, useful drugs include.

(a) *Sedatives*. Amytal $\frac{1}{2}$–$1\frac{1}{2}$ gr. t.d.s. → q.d.s.

At the present time barbiturates are probably overprescribed and it is wiser to use tranquillizers. Nevertheless many patients get better subjective relief from barbiturates. Phenobarbitone should not be used as it causes depression.

(b) *Tranquillizers.* The Tranquillizers commonly used in the treatment of anxiety are:

Meprobamate (Equanil) 200–400 mg. t.d.s. A dose level of 800 mg t.d.s. can be used but is not advisable in view of drowsiness and ataxia which may accompany it.

Chlordiazepoxide (Librium) 10–30 mg t.d.s. is commonly used in the relief of anxiety.

Trifluoperazine (Stelazine) in small doses viz. 2 mg t.d.s. has proved particularly valuable in treating the chronic anxious patient.

(2) *Modified Insulin Treatment*

Small doses of insulin sufficient to induce hypoglycaemic hunger and drowsiness are useful in treating the anxious patient, particularly if anorexia and weight loss are a problem. This form of treatment is usually given to in-patients and day patients but can equally well be given to out-patients.

The dose is given in the morning. The subject is given increasing doses of soluble insulin each day till a dosage level is reached which induces a drowsy relaxed state. After three hours he has a hearty breakfast and glucose drink.

B. PSYCHOLOGICAL

Psychological treatment of anxiety is of two sorts:

psychotherapy,
behaviour therapy.

(1) *Psychotherapy*

Psychotherapy aims to relieve anxiety by discovering causes in the patient's unconscious mental life, by solving problems and resolving conflict. There are many schools of psychotherapy (e.g. Freudian and Jungian), but all subscribe to the belief that behaviour is controlled by unconscious forces and emotion rather than by reason.

The simplest form of psychotherapy is *supportive.* In this the doctor listens and permits the patient to ventilate his feelings and arrive at solutions of problems without guidance or interpretation. The role of the doctor is to provide unbiased sympathy and encouragement.

Analytic psychotherapy aims at exploration of the unconscious. It is necessarily a lengthy process. The most suitable subjects are people with above average intelligence and good verbal ability. The two most widely known schools of analytic psychotherapy are Freudian and Jungian Analysis. All psychotherapeutic methods acknowledge the fundamental importance of the relationship that exists between patient and doctor in psychotherapy. This relationship can vary from one extreme to another as the patient invests the doctor with every sort of emotion. The trained psychotherapist accepts this relationship and handles it as part of the therapeutic process. The patient transfers to the doctor, emotions which previously he had experienced about key figures in his personality development. This is called 'the transference'.

(2) *Behaviour Therapy*

When anxiety is linked to specific stresses (e.g. cats, heights, open spaces) and only triggered off by these, it is called *phobic anxiety*. These phobias may be single or multiple.

In recent years, psychologists studying theories of learning have pointed out that phobias are probably the result of maladaptive learning i.e. the patient has become conditioned to experience anxiety at the sight or sound of a given object. They have reasoned from this that the phobias could be cured by a deconditioning process which desensitizes the patient from the cause of the attacks. This has the advantage of being based on a rational theoretical basis. The most obvious drawback appears to be that its usefulness is limited by the fact that it is only applicable to patients with isolated phobias. Also it ignores the existence of a therapeutic relationship between doctor and patient.

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Manic depressive Psychosis (84)

CHAPTER 3

Affective Disorder

Introduction

In affective disorder the *primary* manifestation is one of *mood disturbance.*

Affective disorder comprises:

(1) Depression: (a) reactive, (b) endogenous
(2) Mania
(3) Manic depressive psychosis (an illness in which mania and depression alternate).

DEPRESSION

In depression the mood resembles sadness or grief but is sustained, unlike the transitory mood change that many people experience in response to various stresses. There is no point in expanding the concept of depression in an attempt to explain every variety of human unhappiness.

The accompaniments of depression are:

(1) insomnia,
(2) loss of energy,
(3) loss of interest,
(4) anorexia,
(5) weight loss,
(6) decreased libido and impotence.

Depressions are often described either as being *reactive* or *endogenous*. Since these terms are in such common use some explanation must be made of them but it is a fact that their *use is controversial.*

Reactive depression is usually so named if the depression can be shown to satisfy the following conditions.

(1) Its onset follows some obvious cause in the patient's life such as loss of a job, broken engagement, examination failure etc.

(2) The content of the illness is concerned with the cause to the exclusion of everything else.

(3) The illness would not have come on if the precipitating event had not ocurred.

Endogenous depression is so named if:

(1) The depression arises out of the blue, unrelated to external events.

(2) There is diurnal variation of mood.

(3) There is sleep disturbance with early morning waking.

In practice the distinction between these two 'types' of depression is hard to make—what at first sight appears to be 'reactive' depression then turns out to be endogenous by virtue of the presence of diurnal mood variation, early waking etc.

Aetiology

1. Heredity

The incidence of depression is about 1 per cent of the population. Family studies of depressive patients show an incidence of depression in about 11 per cent of the relatives as a whole. Broken down the incidence of depression in the relatives of depressive patients is as follows:

Sibs 23 per cent.
Half-sibs 17 per cent.

The type of genetic transmission is not known. A multifactorial inheritance is the most likely.

2. Sex

Depression is more common in women than men.

3. Class

Depression is more common in higher social class.

4. Constitution

(a) *Body Type*. The body type is more predominantly 'pyknic', i.e small extremities and large visceral cavities (Mr. Pickwick).

(b) *Personality*. A personality type notable for swings of mood 'cyclothymic' personality is a common accompaniment of affective disorder.

Many patients who develop *mania* have a premorbid personality notable for unusual jollity and energy—the so-called hypomanic personality.

5. STRESS

The relationship of depression to apparent external causes is often obscure and misleading—causes invoked by patient or relative may be no more than an expression of the illness itself. For example a man presented with a history of depression after dismissal from his job. On closer questioning it became clear that his symptoms of depression had antedated his sacking and that he had lost his job because of his incompetence, itself a manifestation of depression.

6. AGE

Age plays a part in the aetiology of depression, some age groups being particularly vulnerable. Old age with loneliness and the fear of death is the most obvious example. Middle age can be particularly threatening, particularly for the striving man who suddenly arrives at this age and realizes he has accomplished less than he hoped. If this coincides with the loss of his children by marriage etc., it is liable to be all the harder to bear and frank depression may develop. Adolescence is a time of turmoil and depression at this age, though rare, when it does occur is severe.

7. PHYSIOLOGICAL EVENTS PRECIPITATING DEPRESSION

(a) *Childbirth is the first and most obvious example*—an event of physiological and psychological significance. Lability of mood is normal in the puerperium but acute severe depression does occur and needs prompt recognition and treatment.

(b) The *menopause* is a time of hormonal and psychological change and is often accompanied by depression.

(c) *Acute febrile illnesses* such as influenza can trigger off depression.

(d) *Chronic illness,* particularly chronic *painful* illness is commonly accompanied by depression. Unfortunately this depression often passes unrecognized since such depression can be relieved and the illness made more easy to bear.

(e) *Jaundice*

8. SOCIAL FACTORS

Social isolation and insecurity with loneliness and accompanying despair probably account for a large proportion of chronic depression.

9. DRUGS

(a) Reserpine.

(b) Certain anti-parkinsonian agents e.g. Benzhexol may cause depression or states of excitement.

Manifestations of Depression

1. MOOD CHANGE

Mood change is fundamental in every depressive illness. Here it is worth noting that one should not confuse the lay and medical usage of the term 'depression'. When we talk of depression we refer to a *clinical entity* and do not use it loosely to describe transitory feelings of sadness or dejection.

The depressed patient's mood colours his entire mental life; thus in severe depression he will form incorrect judgements—delusional ideas based on his altered mood—e.g. saying that he has been condemned to death for his numerous misdeeds.

Such severe depression is not common, what is much more common is a general depressive colouring to the patient's outlook The world seems grey and dark to him, his future appears grim and he sees himself as a failure, unworthy of anyone's pity or affection. People who feel like this are likely to attempt suicide. Ideas of guilt and unworthiness are extremely common in depression.

2. PSYCHOMOTOR ACTIVITY

Alteration in psychomotor activity follows in the wake of mood change. The patient's movements and talk are slow and ponderous. This is called *retardation*. The patient is aware of this and often describes slowness in thought and difficulty in concentration. These latter can be elicited by simple tests of concentration such as the serial subtraction of seven from one hundred.

Poor concentration shows itself in the patient's work or studies and is confirmed by colleagues who tell one that he is not coping as well with his work as formerly. The housewife finds that work piles up in the home whilst she sits around in a hopeless state unable to concentrate but feeling sad and dejected. Frank weeping is not particularly common in depression. Far more common is the statement 'I've got past the stage of being able to cry. I can't cry any more. Perhaps I'd feel better if I could'.

3. SLEEP DISTURBANCE

Insomnia is very common in depression and may be manifest as delayed sleep, broken sleep or early waking. Early waking is said to be the most common form of persistent sleep disorder. The patient wakes in the early hours and is unable to sleep thereafter he remains awake for a few hours till he gets up unrefreshed. Often he has bad dreams.

4. OTHER BODILY DISTURBANCES

By day the patient lacks energy, interest and appetite. Weight loss is common. Apathy and loss of interest may be the presenting symptoms of depression. Hypochondriacal concern is commonly found, particularly centring on the bowels which are often constipated.

5. OTHER PSYCHOLOGICAL ACCOMPANIMENTS

Anxiety is encountered in almost every depressive illness—there is no point in attempting clinical separation of anxiety from depression. Elderly depressed patients usually show *agitation* that is to say restless semi-purposive overactivity with hand wringing and inability to sit or lie still. Agitation can sometimes be so severe as to resemble manic excitement except that the affect is one of hopelessness and despair. *Paranoid features,* particularly in middle aged and elderly patients may dominate the clinical picture in depression.

Hysterical symptoms can either mask depression or complicate the picture. In the first instance failure to recognize the essential depressive nature of the illness can be very dangerous particularly when the hysterical symptom is protecting the patient from a suicidal impulse.

Differential Diagnosis of Depression

Important physical disorders to be excluded are:

(a) *Myxoedema.* Remembering that in myxoedema, depression and paranoid psychoses are commonly manifestations of the underlying disorder.

(b) *Parkinsonism.* Depression is a common accompaniment of Parkinsonism.

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(c) *Myasthenia Gravis*

(d) *Addison's Disease*

The important psychiatric conditions to be distinguished from depression are:

(a) *Schizophrenia*. Though the presence of thought disorder and true delusions may make the diagnosis of schizophrenia on occasions comparatively simple it has to be remembered that the prodroma of schizophrenia may be apparently entirely depressive, hence adolescent depression should be diagnosed very cautiously.

(b) *Dementia*. Presence of signs of organic deterioration should make diagnosis of dementia possible though atypical depressions may simulate dementia and depression may complicate dementia.

Complications of Depression

1. Suicide. Suicidal risk is hard to assess. Threats can never be ignored and must be carefully evaluated. History of previous attempts and family history of suicide are indications for caution, as are the presence of feelings of guilt and depersonalization. Social isolation is important too—the depressive who lives alone is at greater risk than one who lives with his family.
2. Malnutrition.
3. Worsening of co-existing physical disease through neglect etc., e.g. Pulmonary Tuberculosis, Diabetes Mellitus.
4. Abuse of drugs or alcohol in an attempt to 'fight off' depression.

Treatment

Of all psychiatric disorders depression is the most treatable. Nowadays the majority of depressives are treated as out-patients but admission to hospital will always be necessary for severe depression, particularly where there is suicidal risk.

METHODS OF TREATMENT

1. *General Measures*.

In the present era of physical treatments the possibility of spontaneous remission is not awaited since most psychiatrists rightly feel that the patient's suffering should not be needlessly prolonged.

However it should be remembered that good psychiatric nursing and sedation will always provide comfort and some degree of improvement to the depressed patient.

2. *Physical Treatment*

(a) *Electro-convulsive therapy (E.C.T.)* E.C.T. has come to be regarded as almost specific antidepressive treatment (see Chapter 11). It is usually given twice or three times per week—on the average 8–10 treatments will produce remission of the depressive illness.

(b) *Anti-depressive drugs* including:

Imipramine (Tofranil) 25–50 mg t.d.s. Amitryptiline (Tryptizole) 25–50 mg t.d.s.	Imino dibenzyl derivatives
and Isocarboxazid (Marplan) 10–20 mg t.d.s.	Monoamine oxidase **inhibitor**

(c) *Psychotherapy*. Usually supportive.

(d) *Occupational therapy*.

(e) *Social rehabilitation*.

Prognosis

Depression tends to recur. It may well be that prolonged medication with anti-depressive drugs helps to avert recurrence, though it is too early to be definite about this. The average duration of hospitalization in depression is about six weeks.

MANIA

Mania is less common than depression and tends to be an acute and more circumscribed illness. Chronic depression is commonplace—chronic mania does not exist.

HYPOMANIA is the term used to describe mild or moderate degrees of mania.

Aetiology

(1) See depression.

(2) *Premorbid personality*. Commonly the manic patient is found to have either a cyclothymic personality or else to have always been more energetic and cheerful than his fellows *(hypomanic personality)*.

Manifestations

Mood

The mood is one of cheerfulness—or hilarity. Manic patients are described as showing *infectious jollity*—soon everyone in the room is laughing with them. This is often true, but the jollity is more often than not well laced with irritability and flashes of anger, particularly if someone disagrees with the patient. The manic patient denies all symptoms and says he has never felt better in his life. He is optimistic and has elaborate plans for the future, not only his future but for anyone else who cares to take advantage of the plans he is making. The plans at first may be sensible, if a little over enthusiastically stated but sooner or later they become grandiose as the patient's *critical sense* fades. The patient's *insight* about his lack of judgement is practically nil in mania. Sudden mood changes with transient bouts of tearful sadness are also encountered.

ACTIVITY

The overactivity in mania follows naturally from the feeling of general well being that the patient experiences. His energy is boundless. He gets up before everyone else in the house and goes to bed long after exhausted members of the family have retired. At work he goes from one project to another, completing nothing. He overspends, buys all sorts of things, dresses extravagantly and invites large numbers of unexpected friends home. As activity increases so the patient's *attention* decreases so that he is able to concentrate less on anything.

TALK

Talk reflects the cheery mood and increased activity. The stream of talk gradually increases till it becomes torrential. It flits from topic to topic (flight of ideas), and associations are casual, often triggered by rhymes or puns. Jokes are frequent.

DELUSIONS

True delusions are not found but the manic patient does form delusional ideas based on his overoptimistic views of life in general. It is also not uncommon to find the *irritable manic* showing a *paranoid attitude*, particularly when any objections are made to his plans.

BODILY DISTURBANCE

Sleep is lost through excessive energy.

Appetite is often voracious without any weight gain.

Libido is heightened.

Abuse of alcohol is common.

Mode of Onset

Onset is usually acute and the duration of a manic illness is on the average about 6–8 weeks.

Hypomania often passes unrecognized at first, it is merely remarked by relatives that the patient had seemed full of zest and cheeriness for a few weeks and then things seemed to get out of hand.

Some manic illnesses terminate abruptly, others swing into depression.

DIAGNOSIS

(1) Schizophrenic and schizo-affective psychoses. The presence of true thought disorder and delusions should make the simple diagnosis of these from mania. In practice it is often difficult to be precise about states of excitement. Time usually clarifies the picture.

(2) Drug induced excitement, e.g. amphetamine and its derivatives.

Treatment

(1) ADMISSION TO HOSPITAL

(2) ATTENTION TO FEEDING ETC.

The manic patient may be so overactive that he stops eating for a few days before admission.

(3) MEDICATION

(a) *Sedatives.* Immediate sedation to calm a wildly excited patient can be used but this has generally been replaced by the use of tranquillizers.

(b) *Tranquillizers.* Tranquillizers are extremely useful in calming manic excitement though whether they actually shorten a manic illness is questionable. Commonly used are:

(1) Chlorpromazine: up to 1 g. per 24 h. in divided doses,

(2) Thioridazine (Melleril),

(3) Haloperidol: initially 6 mg b.d. reduced to 3 mg b.d. as soon as a calming effect is noticed. Extra-pyramidal side effects commonly occur with this drug. They can be well controlled with anti-parkinsonian medication.

(4) E.C.T. E.C.T. has a definite place in the treatment of mania. It is usually given with tranquillizers.

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CHAPTER 4

Schizophrenia

Definition

Schizophrenia is a syndrome in which are found specific psychological manifestations recognizable clinically, occurring in younger age groups and commonly leading to disintegration of the personality. The schizophrenic has peculiar ways of thinking and behaving and perceives his environment in an abnormal way. He has an inner life dominated by fantastic ideas, his emotional display is incongruous and he is cut off from his fellows so that he appears to have withdrawn from the world. The syndrome was originally described by Kraepelin (1896) who delineated its essentials under the name'Dementia Praecox', This was a fundamental step in the history of descriptive psychiatry since up till that time what we now recognize as schizophrenia was buried in a multitude of apparently dissimilar syndromes. The name 'Schizophrenia' was applied by Bleuler who viewed the syndrome as being based on a process of psychological disintegration manifesting itself ultimately as a fragmentation of the personality.

Aetiology

1. INCIDENCE

The incidence of schizophrenia is found to be 0.85 per cent of the general population. This figure is remarkably constant whatever populations are surveyed.

2. HEREDITY

That a hereditary factor plays a part in schizophrenia is beyond doubt. Unfortunately the precise means of inheritance is as yet unknown. It is, however, possible to calculate the expectancy of schizophrenia in the family of a schizophrenic. For example, in a schizophrenic's family the percentage of schizophrenia amongst siblings rises from 0·85 to 15 per cent (Kallmann), and the incidence of schizophrenia in parents of schizophrenics is found to be 10 per cent.

3. PERSONALITY

Many writers have stressed the importance of the pre-morbid personality structure of the schizophrenic. As ever one is confronted with the difficulty of assessing personality but even so a 'schizoid personality' has been described. This is a personality type which can be seen to contain the seeds of schizophrenia. Schizoid individuals display behavioural traits such as seclusiveness, abnormal shyness, hypochondriasis, emotional coolness and indifference, fanaticism and eccentricity. However there is some difference found by various workers in the incidence of these abnormal personalities before the onset of schizophrenia. M. Bleuler found a 34% incidence of schizoid personality in a series of schizophrenics. Other workers have found a higher incidence but it has to be admitted that up to 50% of schizophrenics show no evidence of previous personality disorder. Nevertheless the finding of personality disorder in an individual suspected of the slow development of schizophrenia may be a useful pointer toward the diagnosis. Further evidence of the role played by personality abnormality in the aetiology of schizophenia is demonstrated by the increased incidence of deviant individuals in the families of schizophrenics.

4. BODY-BUILD

The incidence of the asthenic body structure has been commented on by many workers. This type of body build is of poor prognostic significance—tending to be associated with chronicity.

5. CHILDHOOD EXPERIENCE

The work of Bowlby (1951) drew attention to the role of maternal affection in personality development. It has been suggested that the individual who experiences maternal rejection has a greater chance of developing schizophrenia than he who is reared in an atmosphere of maternal love. The evidence for this is conflicting and it has been argued that such an individual may have a mother who is herself a personality deviant, and may even be a transmitter of schizophrenic inheritance. Nevertheless schizophrenics do show a significant occurrence of disturbed relationships in childhood.

6 ENDOCRINE AND METABOLIC STUDIES

These have been exhaustive and for the most part unrewarding though there is a growing body of evidence to suggest that the disturbance of schizophrenia may be biochemically transmitted. The precise nature of this disturbance is as yet unknown. The use of hallucinogenic drugs such as lysergic acid diethylamide and mescaline have induced so-called 'model psychoses' in volunteers. In these biochemically induced psychoses workers have seen resemblances to schizophrenia, and it has been argued from this that the schizophrenic psychosis is biochemically determined. This line of enquiry may become more productive when more is known about brain function than at present.

7. PHYSICAL ILLNESS

Physical happenings such as illnesses, operations or accidents can commonly precipitate an acute schizophrenic psychosis or bring about remission in an established one.

8. PSYCHOLOGICAL FACTORS

The role of psychological factors in the aetiology of schizophrenia is far from clear. Common clinical experience teaches us that the schizophrenic may have the illness triggered off by any variety of psychological stress.

A comprehensive theory of the aetiology of schizophrenia would postulate that the schizophrenic process is mediated biochemically i.e. follows a biochemical final common path, that the illness occurs in a genetically pre-disposed individual, and that this disturbance may be triggered off by a variety of physical or psychological stresses or both. It would certainly seem at the present time that this theory of multiple aetiology would be the most profitable one to follow in research.

Manifestations of Schizophrenia

These are best considered under the following headings:

(a) thought disorder,
(b) delusions,
(c) emotional disturbance,
(d) perceptual disturbance,
(e) behavioural disturbance.

The reason for commencing with thought disorder lies in the fact that Bleuler in his original description of schizophrenia stressed the central position of the disturbance of thinking found in schizophrenia.

(a) SCHIZOPHRENIC THOUGHT DISORDER

This is a characteristic disturbance of the thought process peculiar to the schizophrenic syndrome. The schizophrenic's powers of thinking are impaired i.e. his powers of *conceptual thinking are altered*, so that he may interchange cause and effect and draw entirely illogical conclusions from false premises. This will manifest itself by the finding that his talk is difficult to follow. When one examines an example of this talk one finds that the patient has said much but got little across. Closer examination reveals he has uttered a stream of nonsense. Subjectively the patient may be aware of impaired thinking ability and may tell the examiner that he finds it hard to think clearly or that his thoughts are vague, or that he cannot concentrate, or that somehow his thoughts wander. It may be necessary to use leading questions to elicit this information from a patient. As thought disorder is manifest in language, it has been suggested that the schizophrenic is forced to construct for himself a private language to explain his illogical ideas to himself and others.

Attention is often drawn to the phenomenon of *thought blocking*. Here the patient's stream of thought is interrupted, and a new line of thinking begins. It is shown by gaps in the patient's talk and found too in states of exhaustion and depressive retardation. Thought blocking is therefore *not peculiar to schizophrenia*. All the foregoing comments on schizophrenic thought disorder presuppose that the individual is of adequate intelligence. The diagnosis of schizophrenic thought disorder in the presence of sub-normal intelligence would be extremely difficult.

The schizophrenic may experience interruption of thinking and tell the examiner that his *thoughts are being withdrawn* (thought withdrawal) from his head, or that thoughts are being inserted into his head. This sort of complaint is absolutely diagnostic of schizophrenia and occurs in no other condition. In addition he may experience transmission of his own thoughts to others. The term 'schizophrenic thought disorder' refers to the *specific disturbance of conceptual thinking* mentioned at the beginning of this section.

(b) DELUSIONS

A delusion is defined as an incorrect belief which is inappropratc to the individual's socio-cultural background, and which is held in the face of logical argument. True delusions are fundamental errors in judgement and are as inexplicable as they are incomprehensible. They appear suddenly and are held with particular conviction. A distinction is drawn between these true or primary delusions and delusional ideas, since primary delusions are completely incomprehensible whereas delusional ideas are false but nevertheless explicable in the light of the patient's altered emotional state. For instance, in severe depression an individual can develop delusional ideas which can be explained on the grounds of his being sad and therefore believing that his life is finished, his future is hopeless etc. The delusion proper is unshakable and incorrect and held without insight. The content of a patient's delusion reflects his past experience and is coloured by his culture pattern. Thus 100 years ago religious content in delusions was much more common than it is at the moment. Nowadays it is common for deluded patients to believe that they are being persecuted by political organizations such as the Fascists, Communists etc., or that they are being influenced by atomic explosions, radioactivity, radar, television etc. A deluded patient may also experience *ideas of reference*. This is an experience in which the patient finds that mundane happenings of even the most trifling sort have special meaning and significance for him or are directed particularly towards him. Thus a patient has found references to herself in the personal column of The Times, or another patient turned on a TV programme and found that all the characters were making remarks about him. *Passivity feelings* are commonly found in schizophrenia. In this the individual feels that his body or mind are under the influence of or being controlled by other people. Paranoid delusions are delusions of persecution.

(c) EMOTIONAL DISTURBANCE

Affective incongruity is typically found in severe schizophrenic illnesses. In this the patient's emotional display is inappropriate to his condition. In its most crude form one finds a patient laughing callously when being given some tragic news, or talking of some serious happening. In the majority of instances we find that the emotional incongruity of schizophrenia is not so marked as the lack of emotional rapport which one can make with a schizophrenic. Many people have spoken of the pane of glass which separates one from the schizophrenic patient. It is difficult to identify with or empathize with a schizophrenic. His emotional display is limited: he is cool, detached, rather 'couldn't care less'. He is unmoved by the various things going on around him and concerned only with his own private world. Other variations of emotion are found in schizophrenia too. It is not uncommon for a schizophrenic illness to be ushered in by a state of depression or anxiety or even mild hypomanic excitement. In fact it is fair to say that any young patient i.e. adolescent patient, who presents with severe anxiety, inexplicable depression or acute hypomanic excitement must be suspected of a developing schizophrenia until it has been proved otherwise.

(d) PERCEPTUAL DISTURBANCE

The commonest perceptual disturbances of schizophrenia is the hallucination which is most commonly auditory. It is important always to enquire closely into the content and nature of the hallucinations. Patients may hear voices commenting on their actions, speaking their own thoughts aloud, uttering obscene words or phrases or telling them what to do. The voices may be familiar or unfamiliar, single or multiple. The majority of schizophrenic patients develop hallucinations at one stage or another during the illness.

(e) BEHAVIOURAL DISTURBANCE

In the development of schizophrenia one looks for alteration of the total behaviour of the individual rather than isolated phenomena. Often the relatives will describe how the individual has become more and more seclusive over a period of months, has appeared odd and made use of unfamiliar gestures, has shunned friends and familiar activities. States of ecstasy, wild excitement and impulsive behaviour also occur in schizophrenia but probably the most common finding is a general falling off in activity. The scholar becomes less studious and the professional man less interested and able to perform his work. Periods of apparent inactivity may be interspersed with occasional bouts of rather purposeless enthusiasm for some hobby or other. Thus a schizophrenic was said to be spending much time on 'research'. When investigated this turned out to be a method of preserving butterflies' wings in some plastic substance which was somehow allied to a thesis on biochemistry. Outbursts of violence or senseless criminal acts are fortunately rare but can occur. Altered moral standards may be seen in developing schizophrenia, thus a young girl previously puritanical may become promiscuous, and it may be this concern about her sexual morals which brings her parents to consult the doctor, and the diagnosis of schizophrenia made. Any history of personality change in a young person must always raise the suspicion of schizophrenia.

Clinical Types

(a) SCHIZOPHRENIA SIMPLEX

Simple schizophrenia is characterized by a general lowering of all mental activity. The simple schizophrenic presents with poverty of activity, volition, affect and thought. This variety of schizophrenia is most commonly confused with mental subnormality. Indeed the two clinical pictures may be indistinguishable. The onset is usually slow and insidious and the prognosis in general very bad.

(b) HEBEPHRENIA

As its name implies this is seen in the younger age groups and typically the clinical picture is one of rather fatuous euphoria and hallucinosis. Here the onset tends to be insidious and the prognosis bad.

(c) CATATONIC SCHIZOPHRENIA

In catatonic schizophrenia muscle tone is altered (waxy flexibility), strange postures are adopted. These have a symbolic meaning for the patient. Mutism and stupor occur. Repetitive words and movements can become established and fixed (stereotypy). States of wild excitement are encountered in catatonic schizophrenia. The onset is commonly acute. Other behavioural abnormalities found in catatonic schizophrenia include *automatic obedience,* in which the patient carries out every instruction given to him, *echolalia,* the repetition of the last few syllables of everything said to him and *echopraxia,* performing the same actions as the examiner.

(d) PARANOID SCHIZOPHRENIA

Characterized by the development of systems of paranoid delusions. The onset is slow and insidious. Paranoid schizophrenia is often associated with considerable preservation of the personality, so that the paranoid schizophrenic may be able to remain for a considerable time in the community and conceal his paranoid delusions. It is found in older age groups (30 and over).

General Comments on the Clinical Types

Many schizophrenic patients do not fall into any of these groups and it is questionable whether the differentiation is useful. In making the diagnosis of schizophrenia one looks for:

(a) thought disorder,
(b) passivity feelings,
(c) delusions.

in particular. The history of change in personality is often the most revealing pointer.

Differential Diagnosis

The differential diagnosis of schizophrenia includes:

(1) mania,
(2) depression,
(3) depression with paranoid features,
(4) personality disorder,
(5) hysteria.

The presence of affective disturbance of depressive type will of course always raise a suspicion of depression but it must not be forgotten that schizophrenics can be depressed.

Hysteria is often difficult to distinguish, but one looks for previous factors which would contribute to the development of an hysterical illness, such as a hysterical personality.

Treatment

No psychiatric topic is more beset with pitfalls than the treatment of schizophrenia. Since this is a poorly comprehended condition it is therefore difficult to treat adequately and impossible to treat specifically. This leads on the one hand to therapeutic nihilism and neglect of the patient and on the other to over treatment based on tenuous theory making the syndrome a perpetual testing ground. It is difficult to know which is the more dangerous of the two alternatives.

The treatment of the schizophrenic patient should consist of *a total approach to the patient*, aiming at strengthening his ties with reality and rehabilitating him. In the acute stage of the illness the patient may need to be in hospital and may have to be protected from himself since suicide commonly occurs in schizophrenia—he may need to be calmed by sedatives and tranquillizers, and his general state of health may need investigation, for co-existing physical diseases which, if found are appropriately treated.

At the present time the phenothiazine drugs, particularly *chlorpromazine* and *stelazine*, are found particularly useful to influence the mental state of the schizophrenic. These drugs not only calm but also alter perception and modify thinking. Chlorpromazine is given orally (50–200 mg t.d.s.) or by injection. Stelazine is given orally (5–15 mg t.d.s.).

Use of E.C.T. in schizophrenia is controversial. Certainly it is of value in a schizophrenic illness of acute onset, and where affective features are present. Where it is used many authorities favour a course of twenty treatments.

Psychotherapy plays a part in the treatment of schizophrenia. It is of a supportive and reintegrative rather than analytic type. A psychotic patient cannot tolerate interpretations of his behaviour, and indeed such therapy can often be dangerously disruptive.

It is important to find useful and variable occupation for the patient. This may start with traditional occupational therapy. On the other hand there is much evidence to suggest that occupation of a constructive sort may be particularly valuable. The current interest in the reclamation of the chronic schizophrenic has shown the value of 'industrial therapy'. In industrial therapy units chronic schizophrenics perform meaningful tasks producing various objects, e.g. light industrial assembly work etc., emphasis being placed on making the situation as near to a normal work situation as possible. This encourages the patient to adopt a normal working role, and prepares him for a return to the community and the consequent return to gainful occupation.

Treatment of the schizophrenic patient is often difficult and unrewarding but chronicity can be avoided if emphasis is placed on strengthening the patient's ties with reality, i.e. with the community at large and facilitating his return to that community as soon as is reasonably possible and avoiding conditions of social neglect. There is much evidence to suggest that many of the features previously held to be typical of chronic schizophrenia are in fact features of social neglect.

Prognosis

Making an accurate prognosis of schizophrenia is difficult but there are a few useful pointers. The following features may be regarded as good prognostic signs :

1. Acute onset.
2. The presence of psychological or physical precipitants, e.g. child-birth, operations, etc.
3. Normal pre-morbid personality.
4. Stable social background, i.e. close social ties etc.
5. The presence of affective features.
6. Average or above average intelligence.

The following are poor prognostic features:

1. Insidious onset.
2. Persistent thought disorder.
3. Asthenic bodily habitus.
4. Presence of flattening of affect.
5. Subnormal intelligence.

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CHAPTER 5

Organic Syndromes dementia, delirium and allied states

Disturbances of cerebral function consequent on gross physical or subtle neuro-chemical damage lead to recognizable disorders which are called 'organic syndromes'. In organic syndromes the predominant impairment is of *cognitive function.* Affective symptoms, anxiety etc., are purely secondary.

Organic syndromes comprise two main groups:

(1) *Delirium and Allied Conditions*

being characterized by	overactivity clouded consciousness hallucinosis	acute delirium
and	perplexity clouded consciousness incoherent thought	subacute delirium ('confusional state')

(2) *Dementia*

(a) Primary (being caused by unknown agents e.g. Pick's, Alzheimer's)

(b) Secondary (where the cause is known e.g. arteriosclerosis, tumour)

DELIRIUM AND SUBACUTE DELIRIUM

Clinical Manifestations

The most striking finding in states of delirium is the *impairment of consciousness.* In acute delirium this is severe—in its mildest form it is found in the feelings of 'muzziness in the head' that people experience in influenza etc.

With impaired consciousness the individual's *awareness* of himself and of his surroundings is impaired. Also the level of wakefulness may be affected. The delirious child is often alarmingly bright-eyed and chatty. Wakefulness, on the other hand may be reduced, producing a drowsy appearance. With impaired awareness and recognition of the surroundings is found *poor attention* and *concentration* so that a patient when asked cannot perform simple tasks such as washing or tying his pyjama cord without getting lost halfway through. He *cannot register* the information coming in from his environment so naturally fails in tests of memory of a simple sort.

Disorientation for time and place is invariably present and severe. *Perception* is altered, either subtly or grossly. Subtle perceptual alteration is usually first noticed by the patient saying that every thing around seems clearer and sharper. Later in delirium *gross perceptual errors* occur (illusions). When this happens the patient mistakes patterns on the wallpaper for insects and animals, shadows become menacing people and bedside consultations are heard as sinister plots. Finally the patient experiences *Hallucinosis*. Visual hallucinations are common in delirium. They can take many forms. Perhaps the most common are small objects moving quickly across the visual field, e.g. in alcoholic delirium tremens patients often see small animals crawling all over the room. Hallucinations of this sort are described vividly by the patient and frequently appear clearly in his field of vision. Even their bizarre appearance is greeted without surprise, e.g. a patient recovering from chronic barbiturate intoxication saw a six inch tall manikin running around the room and hiding under the floodboards. She identified it as her husband but could not understand why no one would let her prise up the floorboards to let him out. When prevented she became homicidally violent.

Motor disturbance in delirium varies from overactivity in acute delirium to mild irritability seen in subacute delirium. The severe overactivity can be prolonged and exhausting and represents a considerable physical hazard to the patient. The patient is restless, particularly at night, will not stay in bed, and is found wandering about the ward peering out of windows, searching and muttering to himself. He insists on leaving the ward; he must go to work; he makes a collection of his belongings, arranges and rearranges them, but such is his incoherent thinking that it all gets in a muddle and he starts all over again.

Emotional symptoms are common. States of panic and terror are usually abrupt in onset, the patient acting under the influence of his misperception of his environment. *Milder emotional symptoms* are often missed; this is unfortunate because if recognized they are useful signposts. The mildly delirious patient feels *vaguely apprehensive and uncomfortable,* and cannot say why. This may be noticed by the nurses who are surprised to find Mr X. unusually uncooperative, having refused his supper.

Delusional ideas in delirium are loose and unformulated and come from the chaotic perceptions that the patient experiences. They never have the clarity and conviction of true schizophrenic delusions.

Physical Examination of the delirious patient may reveal common causes such as:

(a) alcohol,
(b) pneumonia,
(c) barbiturate intoxication (chronic),

but the delirious state itself induces secondary physical changes as the patient refuses food and fluids so that he may show signs of:

(a) dehydration,
(b) vitamin depletion,

and further psychological disturbance, so that a vicious circle is set up.

The diagnosis of delirium is not difficult to make providing the examiner concentrates on establishing the state of consciousness and orientation for time and place. Impairment of consciousness and orientation do not occur in schizophrenia nor in mania.

Acute delirium is usually of short duration. Subacute delirious states can last for weeks.

DEMENTIA

Clinical Manifestations

In dementia there is *progressive and irreversible intellectual deterioration* consequent on brain damage. The damaged brain cannot absorb and store new information and this is manifest by *impairment of recent memory* which is usually the most striking finding. Patients may complain of this memory defect or it may be noticed by others and not mentioned by the patient. Often patients attempt to overcome this memory defect by keeping a notebook reminding them to do things; this is usually successful for a while but sooner or later the problem overwhelms him and he presents anxious and bewildered, fogged by a day's routine which he cannot recall. *Behaviour* shows a deterioration, *interest, activity* and *energy* fall off, the professional man copes less easily with his work, the housewife cannot keep up with her chores, the gas is turned on but not lit. Unusual behaviour e.g. masturbation, self-exposure, shoplifting, can appear as a release phenomenon and with its attendant legal consequences bring about the recognition of the underlying process. *The appearance* deteriorates, clothes become unkempt and stained with food. The decline is overall. leading ultimately to helpless incontinence. *Concentration* is impaired. This can be elicited easily by simple tests such as the serial subtraction of seven from one hundred. The patient is often aware of his poor ability and becomes very upset, angry, tearful and agitated when he is confronted with a task which proves too much for him. This is called the *catastrophic reaction*.

The fundamental impairments of brain function in organic brain disease are well demonstrated when this occurs. Organic brain disease produces rigidity of thinking, impairment of grasp and consequent difficulty in problem solving. Psychological tests of brain damage are designed to search for this sort of dysfunction and also to demonstrate difficulty in shifting from abstract to concrete and vice versa.

EMOTIONAL CHANGES IN DEMENTIA

There are no specific emotional disturbances. They tend to reflect in an exaggerated form the individual's previous patterns of emotional display. Lability of mood is common as control weakens and in advanced dementia one finds states of 'emotional incontinence'. Depression is common and usually ascribed to the patient's awareness of his plight. *Hysterical symptoms* may appear early in a dementing process. It is suggested that they are caused by the lower order of central nervous control and integration brought about by brain damage.

The diagnosis of dementia

The diagnosis of dementia is not difficult when the clinical picture is typical. However there are difficulties particularly when confronted with middle-aged patients in whom dementia may be suspected purely on the grounds of a history, say, of falling off of interest and energy for many months with some associated mood change. In such a case chronic depression may account for the whole illness, but this may not be so, and one may be left with a patient whom one has to keep under observation.

Aetiology of Dementia and Delirium

Having found signs of an organic mental state, one is next concerned with finding the underlying cause. The commonest factors causing organic mental syndromes include:

1. CEREBRAL HYPOXIA

Dementia following cerebral arteriosclerosis gradually depriving brain of oxygen.
Dementia following prolonged coma e.g. after carbon monoxide poisoning.
Delirium following cerebral haemorrhage.
Delirium associated with severe pernicious anaemia.

2. DEHYDRATION AND ELECTROLYTE IMBALANCE

Delirium due to post operative fluid loss.
Delirium in uraemia.

3. VITAMIN DEFICIENCY

Wernicke's encephalopathy.
Alcoholic delirium tremens.

4. CHRONIC INTOXICATIONS

Barbiturates.
Alcoholic—alcoholic dementia.

5. GROSS CEREBRAL DAMAGE

Tumour.
Chronic inflammation: general paralysis.
Head injury causing post-traumatic delirium and dementia.

Investigation of Organic Syndromes

Physical examination may reveal the cause of delirium or dementia and may reveal localizing cerebral signs. Commonly however, physical examination is negative, particularly in cases of dementia, so one employs laboratory and other investigations to clarify the picture. They include:

(1) W. R. and Kahn,
(2) skull X-ray,
(3) E.E.G.

(4) C.S.F. Examination,
(5) air encephalogram,
(6) cerebral arteriogram.

Treatment of Organic Syndromes

GENERAL MEASURES

Delirium

The patient should be nursed in quiet surroundings with minimal interference. Calm doctors and nurses reassure the frightened delirious patient and help to maintain contact with reality however tenuous.

The evening and night time are occasions of heightened overactivity so the patient needs adequate sedation. It is wise to avoid using barbiturates and paraldehyde which may worsen confusion and produce discomfort. Phenothiazine tranquillizers can be given with safety. Diet and fluid should be kept up to the required level and symptomatic treatment with high doses of vitamins is usually given. This should take the form of intravenous parentrovite, 10 ml. given 4 hourly for 24 h, then reduced to ml. 10 twice daily intravenously for 24 h and then 4 ml intramuscularly daily for 5 days.

Dementia

The first thing is to find out the extent of the patient's disability so that one can provide him with an environment which is stimulating enough to prevent too rapid deterioration and not too demanding of him.

Vitamin B given by mouth is usually given, though the value of this is doubtful.

Occupational therapy and social therapy have a limited though supportive part to play by providing stimulation and preventing social deterioration.

SPECIAL MEASURES

In the treatment of delirium and dementia special measures depend on the nature of the underlying disorder if any—for example adequate anti-syphilitic treatment.

SOME SPECIAL EXAMPLES OF ORGANIC SYNDROMES

1. Conditions caused by Vitamin Deficiency

(a) KORSAKOV SYNDROME

This is usually found in association with chronic alcoholism and is caused by vitamin B deficiency. The manifestations of the syndrome are:

(1) gross impairment of recent memory,
(2) confabulation,
(3) disorientation.

Typically the patient claims recognition of the doctor and describes in detail having met him before, when in fact he has never seen him, or will recount in detail the fancied happenings of the previous day—*confabulation.*

Recent memory is so poor that though the examiner may have told the patient his name, he is unable to recollect it a minute later.

The lesion is in the mamillary bodies, the onset usually follows delirium tremens. The prognosis is bad.

(b) WERNICKE'S ENCEPHALOPATHY

Also caused by vitamin B deficiency and found in association with alcoholism. The main manifestations are ocular palsies and states of subacute delirium.

(c) PELLAGRA

Pellagrinous psychoses are predominantly of a subacute delirious sort. The cause is vitamin B deficiency. Untreated the psychosis proceeds to dementia.

2. Cardiovascular Disease

(a) CARDIAC FAILURE

Patients in cardiac failure are often subject to bouts of mild confusion or subacute delirium at night. This is caused by relative cerebral hypoxia and responds to further treatment of the cardiac condition.

(b) ARTERIO-SCLEROTIC DEMENTIA

There is no characteristic clinical picture in dementia due to cerebral arteriosclerosis. Usually the diagnosis is made by demonstrating the presence of generalized cerebralvascular disease in a patient with established dementia.

(c) THROMBOSIS OF THE INTERNAL CAROTID ARTERY

Occlusion of the internal carotid arteries can give rise to dementia usually complicated by focal cerebral signs. A typical history would include transient losses of power in one or other limbs occurring over a period of months followed by gradual alteration in memory.

3. Cerebral Syphilis

General Paralysis of the Insane (G.P.I.)

Now that syphilis is properly treated in its early stages, the full blown picture of G.P.I. is rarely seen. The first signs of G.P.I. are usually those of sudden personality change, with radical alteration of the patient's previous ethical and moral standards. This is followed by grandiose and extravagant behaviour. After this the picture settles into one of dementia with failing memory and general deterioration. The affective state is usually one of flat euphoria. Spastic paralysis, pupillary abnormalities and physical deterioration are late manifestations.

4. Syndromes following Head Injury

Dementia can follow severe head injury, as can fits which are a common sequel of head injury of whatever severity.

Traumatic Dementia usually follows extensive destruction of brain tissue. States of delirium with complete recovery can also follow severe head injury.

The term *post contusional syndrome* is usually applied to a constellation of mild chronic symptoms including headache, dizziness and general feelings of weakness and inability to concentrate. This syndrome is regarded as being constitutionally determined and released by injury. Post contusional syndromes can present difficult problems in management. In general it is advisable for patients to return to normal life and work as soon as reasonably possible since it has been found that convalescence prolonged unnecessarily delays rehabilitation and fixes neurotic symptoms.

The morale of patients is always improved by confident management, maximum reassurance and vigorous rehabilitation.

5. Other Dementias

(a) SENILE DEMENTIA

A distinction is usually drawn between senile dementia and cerebral arterio sclerosis since cerebral arterio sclerosis can have its onset in the pre-senile age groups whereas by definition senile dementia comes on after the age of 65. Commonly the first manifestations of senile dementia are exaggeration of the basic changes of ageing, namely increased rigidity of thinking, greater egocentricity, lessened emotional control. These exaggerations may precede the appearance of frank evidence of dementia, while not for many years, inevitably though, memory impairment, poor concentration and impaired performance show themselves, whilst the individual's social behaviour becomes less tolerable. Neglect of the self, appearance and so on become more marked, and the individual enters a decline of all his mental powers until he ends up as an empty shell of his former self, incontinent, helpless, incapable of grasping what is going on around him.

(b) PRE-SENILE DEMENTIA

By definition pre-senile dementia can occur from any age from infancy up to the age of 65 though usually the term is used to cover the age range 45–65. The two most commonly described forms of pre-senile dementia are Alzheimer's disease and Pick's disease.

Alzheimer's disease

Here destruction of brain tissue from unknown causes affects the cortex as a whole. Abnormal affective states are commonly seen and fits may occur. The dementing process is usually fairly rapidly progressive.

Pick's disease

In this condition cerebral atrophy is mainly confined to the frontal and parietal areas, so that commonly its presentation is as a frontal lobe syndrome with impaired moral standards. This fades into a clinical picture of dementia.

(c) HUNTINGTON'S CHOREA

This is a genetically determined form of dementia. The inheritance is caused by dominant genes. The manifestations of Huntington's Chorea are choreiform movements and altered mental states leading inevitably to dementia. A wide range of psychiatric symptomatology may be seen before dementia becomes evident, although the most commonly found psychoses are paranoid in type. Suicide, alcoholism and personality disorders are common in Huntington families.

6. Syndromes Associated with Epilepsy

(a) Mood disturbance often precedes the onset of fits, or follows them.

(b) In temporal lobe epilepsy episodic mood disturbance or outbursts of rage may be caused by the epileptic discharge and be accompanied by appropriate E.E.G. changes.

(c) Personality change is described in long standing epilepsy. The changes described include increased religiosity, rigidity, seclusiveness, difficult social behaviour and a curious arrogant smugness said to be quite characteristic.

(d) Psychoses are found in association with epilepsy. They are schizophreniform. The current view is that these are symptomatic psychoses, i.e. psychoses having their origin in the epileptic process and not independent of it.

7. Syndromes Associated with Cerebral Tumour

The common modes of presentation of cerebral tumour are:

(a) epilepsy,

(b) signs of raised intracranial pressure
  e.g. headache
    papilloedema
    nausea
    vertigo

(c) manifestations of local or generalized brain damage
  e.g. dysphasia
    apraxia
    dementia
    paresis.

However it is not uncommon for tumours to present with apparently 'pure' psychiatric symptoms. Even more misleading can be the occurrence of tumour in a patient with longstanding neurotic complaints. In either instance if the doctor is not alert the diagnosis will be missed until signs of gross damage appear.

Probably about 50% of patients with cerebral tumour present in this way, i.e. with psychiatric symptomatology. This places a critical diagnostic burden on anyone evaluating such symptoms, particularly in children and in patients of middle age who are most at risk for tumour development.

The following manifestations should always be enquired about most carefully, and evaluated.

1. subtle, insidious personality change
2. deterioration in appearance
3 altered ethical and moral standards
4. recent affective flattening, insouciance and apathy
5. unusual flippancy

point to frontal lobe tumours

6. poor concentration 7. memory impairment 8. hallucinations	point to temporal lobe tumours
9. bouts of sleepiness	point to third ventricle tumours.

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CHAPTER 6

Abnormal Personality, Psychopathy and Hysteria

Many people behave abnormally from their earliest years. This abnormality can show itself in antisocial acts, drug addiction. social inadequacy, undue vulnerability or in eccentricity of one sort or another. It is part of their constitution rather than an acquired illness and for this reason is ascribed to their having *abnormal personalities*.

PERSONALITY—NORMAL AND ABNORMAL

Personality is the sum of many different varying characteristics, intellectual, affective and physical, to name only a few, which gives to each person both an individuality and a resemblance to his fellows. These characteristics are present to some degree in everyone so that to speak of *normal* and *abnormal personality* is not to postulate end points separating the two categories, but rather to define an individual's personality as lying somewhere along a curve of normal distribution. In this way the abnormals are those who deviate markedly from the average and the normals are the bulk of the population. This method of considering personality has the great advantage of being *experimentally* valuable. Investigators can then go further and attempt to establish the psychological and physiological correlates of given personality characteristics. Much valuable work of this sort has already been carried out. The psychiatric approach to the study of *abnormal personalities* has in the main been a clinical one and has not been made easy to follow by the use of the term *psychopath*. In general, psychiatrists have tended to call psychopaths those patients with abnormal personalities but this is not universally so. The two concepts of psychopathy and personality disorder were most succinctly united by Schneider who defined psychopaths as *those abnormal personalities who suffer from their abnormality or cause society to suffer*. This definition is the one used in this book. It has one very important advantage, namely that it recognizes that someone can have an abnormal personality without being regarded in some way as ill or antisocial i.e. distinguishes between 'pathological' and 'non-pathological' abnormal personalities. This is important because the term psychopath has come to be regarded in Anglo-American circles anyway, almost as a term of abuse.

Unfortunately the picture (in England and Wales) is made more complicated by the Mental Health Act of 1959, in which the definition of psychopathic disorder stresses irresponsible or anti-social conduct.

Psychiatrists have classified psychopaths in two main ways; first by naming groups whose personality disorder resembles a clinical syndrome, e.g. schizoid psychopath, hysterical psychopath and secondly, by naming groups by picking out a dominant behavioural trait, e.g. inadequate psychopath, agressive psychopath.

Variations of Abnormal Personalities

1. NON-PATHOLOGICAL

Many people of undoubted genius fall into this category. Some authorities would call them psychopaths but there seems no justification for this.

2. PATHOLOGICAL (= PSYCHOPATHS)

The abnormalities which cause symptoms include:

Neuroticism
Instability
Lability of mood
Abuse of drugs

} may lead to admission to hospital

The abnormalities which offend society include:

Suicidal gestures
Antisocial behaviour—recidivism
Lack of foresight leading to gratification of any need
Explosive behaviour
Sexual perversions
Social inadequacy
Inability to maintain stable interpersonal relationships

} may lead to hospital, or more commonly to prison.

The striking feature of so many psychopaths is their *remarkably degree of immaturity* of personality development. They react to the whim of the moment in much the same way as does a small child who has tantrums if his wishes are not gratified immediately. The same sort of thing leads them into crimes which can have disastrous consequences.

Treatment

There is no treatment which can transform someone's personality, on the other hand prolonged psychotherapy can be helpful to the intelligent psychopath—it is a way of focussing on his problems whilst he forms a relationship with the therapist.

Social rehabilitation of the antisocial psychopath is attempted by group therapy in special communities (therapeutic community). In these, the traditional hierarchical hospital structure is done away with since psychopaths do not do well in such a situation. Instead the approach to the patient acknowledges the importance of social forces and of the community as a whole in influencing behaviour. The unit is run on democratic rather than autocratic lines and the whole community of patients and staff share the responsibility for determining the behaviours that they can tolerate (Rapaport 1960). There is growing evidence to show that psychopaths do well in such units.

MEDICATION

(a) Tranquillizers and sedatives may be used in helping psychopaths through crises but there is no justification for routine long term medication except in the case of aggressive psychopaths who can be kept calm with phenothiazines.

(b) Antidepressive drugs may be used when sustained depression is encountered.

HYSTERIA

The word hysteria is used in at least four ways.

(1) To describe a variety of abnormal personality: *Hysterical personality*.

(2) To describe certain disorders, *hysterical disorders (conversion hysteria)*, in which there is loss of function without organic damage.

These disorders are induced by stress and the patient is unconscious of the mechanism.

(3) To describe unconscious exaggeration of organic disease, so called *'hysterical overlay'* or 'hysterical exaggeration'.

(4) To describe states of mind in which an individual becomes 'out of control', 'beside herself'. This is a lay use of the term, but used surprisingly frequently by doctors.

1. Hysterical Personality

The term 'hysterical personality' is used to describe a particular type of individual who is himself the more likely to develop hysterical symptoms. Such individuals show the following traits:

(a) Affective immaturity often allied to an appearance of physical immaturity.

(b) Egocentricity allied to a remarkable capacity for self deception.

(c) Histrionic behaviour. To the hysteric the world is either hell or heaven. Extremes of feeling easily aroused and as easily dissipated are commonplace. This is reflected in their appearance in striking fashion. At one moment the patient is an ashen faced weeping wreck threatening suicide, disrupting the whole atmosphere of the ward—hours later or less, she is the most vivacious and sought after partner at the hospital dance.

(d) Inability to tolerate or maintain inter personal relationships of any depth.

Of course the hysteric possesses these traits to an excessive degree—they are common enough in normal people. Under certain circumstances the hysterical personality can be an asset e.g. in the theatre.

2. Hysterical Disorders (conversion hysteria)

In hysterical disorders there is loss of function without organic damage. This arises as a result of stress usually in a susceptible person but can occur in otherwise normal individuals in face of overwhelming stresses (e.g. disasters, wartime etc.).

The lost function protects the patient from further harm. 'Is the illness simulated?' it may be asked. The answer is 'Yes, but the patient is wholly or partly unaware of this'.

Hysterical disorders may be of a wide variety. Most commonly they affect higher functions and the central nervous system producing amnesia, paralysis, sensory loss etc. Hysteria can also produce pseudo dementia in which the patient develops an apparent psychotic state. The signs of 'psychosis' confirm to the lawman's idea of madness, e.g. when asked how many legs has a cow a patient might answer 'five'. Pains can be hysterical in origin. When this is so it is a common error to suppose that the patient is therefore not experiencing discomfort but is feigning. As so little is known about the mechanism of pain there seems no justification for this belief. It is wiser to acknowledge that the patient is in pain and try and discover the cause. Pain is pain whether hysterical or not, and the label hysterical should not be allowed to cause patients to be subjected to the sort of hostile treatment that they may provoke by their admittedly often demanding and rather ruthless behaviour.

Aetiology of Hysteria

1. The role of the hysterical personality has been mentioned. There is strong evidence to support the belief that genetic factors are important in this.
2. It is likely too that upbringing can reinforce already dominant hysterical traits. The doting parent who accedes to every whim of an unstable egocentric child is probably doing this unwittingly.
3. *Brain damage, mental subnormality and chronic psychosis* all predispose to hysteria by lowering higher control and integration. Hysteria is commonplace amongst long term mental hospital patients.
4. Hysterical disorders are danger signals. The undiagnosed depressive or the incipient schizophrene who finds his inner life mysteriously disrupted—both may develop hysterical symptoms as an unconscious call for help.
5. The manifestations of hysteria conform to:
   (a) the patient's notion of illness, thus sensory loss is of 'glove' or 'stocking' distribution.
   (b) ideas of disease implanted in the patient's mind by others either by suggestion or example. Doctors can suggest the former and other patients the latter by their own symptoms.
6. The psychodynamic explanation of hysterical disorder is that the failure in function always arises as a result of unconscious conflict or buried psychic trauma which threaten the individual's integrity to such an extent that he responds by switching off a function thus making it unnecessary to continue in the stressful situation as he is now ill and can opt out of the situation demanding his attention. This switching off is referred to as dissociation.

Diagnosis of Hysteria

Since hysteria can mimic so many other illnesses the differential diagnosis is limitless. The diagnosis should be made on positive and not negative grounds; it is not good enough to investigate a patient's complaints and, having found no abnormality, fall back on hysteria as a convenient dumping ground.

One must have adequate reasons for making the diagnosis so that one can look at the patient's history and life situation and see with certainty that a hysterical disorder is the inevitable outcome of all that has gone before.

Hysteria is a diagnosis that is often made lightly by the inexperienced, purely on the basis of a few negative results.

Treatment of Hysteria

(a) HYSTERICAL PERSONALITY DISORDER

Such patients usually make brief dramatic appearances in hospital following suicidal gestures, marital strife or any acute stress that is too much for their level of tolerance. Mood disturbances may be prominent but rarely sustained.

Tranquillizing drugs may be needed to calm the patient in a period of acute crisis. The object should be to make the period of hospital stay as short as possible to tide the patient over the crisis.

After this, treatment either consists of:

(1) Simple supportive therapy,

(2) Prolonged psychotherapy aimed at helping the patient towards insight and a higher level of emotional maturity.

(b) HYSTERICAL DISORDER (CONVERSION HYSTERIA)

General:

It is important to treat the patient actively i.e. to do everything possible that will help to convince him that total function will return. At the same time one has to avoid focussing too much on the symptom and reinforcing it in the patient's mind.

This can be done fairly easily as long as doctors and nurses approach the patient as a team and with full knowledge of each other's roles. Difference of opinion and uncertainty feed hysteria. The patient, sensing differing attitudes, questions different people, gets different answers and his symptoms intensify and proliferate.

Abreaction

Freud used this term to describe the re-living of emotionally charged experiences said to have caused hysterical breakdown. Abreaction has a place in the treatment of hysteria but is most successful in the acute disorder, i.e. immediately following some traumatic experience.

Abreaction is encouraged in a state of altered consciousness—usually brought about by giving intravenous sodium amytal (3¾–7 gr). In theory the patient regains the lost function once he has ventilated the pent up feeling that surrounds the traumatic scene.

Psychotherapy

The alternatives are:

(a) supportive therapy, ,

(b) commencing exploratory psychotherapy with the object of helping the patient to understand the nature of his illness and how it relates to his life situation. This means embarking on fairly prolonged psychotherapy.

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CHAPTER 7

Obsessional Illness

Obsessions and compulsions are similar though not identical psychological manifestations. Their similarity lies in the fact that they are both experienced against an inner feeling of resistance. Obsessions are contents of consciousness i.e. ideas or thoughts which the patient has and which he tries to push away. Sometimes they develop into acts, utterances or rituals, and become repetitive, in which case they are called compulsions. In practice they are described collectively by the term obsessive compulsive phenomena.

Aetiology

1. NORMAL DEVELOPMENT

Everyone has experienced the 'tune that keeps running through the head', or the rituals practised in childhood e.g. walking on paving stones avoiding the lines. These are part of normal life and development and resemble obsessive compulsive phenomena. Children often use these rituals in a magical way to defend themselves from fancied harm. It has been suggested that rituals are used in a similar way in obsessional illness.

2. PERSONALITY TYPE

Some people are from their early years over meticulous and unduly scrupulous. They show excessive concern for order and tidiness in dress and in their surroundings. Their talk is precise, even pedantic, while their outlook is excessively moral and rigid. They tend to be indecisive, vacillatory and hypochondriacal. Their indecisiveness makes them good subordinates but poor leaders. They lack imagination or creative ability, and humour, when present, is of an arid donnish sort. These sort of traits constitute the *obsessional personality*. If such people become psychologically ill, they develop obsessional symptoms.

3. RELATION TO BRAIN DAMAGE

(a) Obsessional symptoms are definitely associated with the personality changes following encephalitis lethargica.

(b) The brain damaged patient often develops obsessional tidiness, 'organic orderliness'. This can be seen as the way in which a progressively handicapped individual attempts to impose order on an environment that is becoming too much for him.

Manifestations of Obsessional illness

Obsessional symptoms tend to focus on daily activities such as eating, dressing, washing and defaecation—a patient complained that she was unable to eat as she spent hours removing solid particles from food matter—another patient never finished her housework as she felt obliged to repeat the washing up time and time again—a patient could not get to work on time as he was delayed by elaborate rituals surrounding his morning defaecation.

Usually the patient seeks medical advice because the symptom has *got out of hand*. It has usually been present for some time but recently become troublesome.

Mood change of a depressive sort is a common association, obsessions get worse with depression and vice versa, so a vicious circle is set up.

Anguish, anxiety and tension are frequent accompaniments. The obsessional's tendency to self-criticism is unduly exaggerated. He describes the symptoms of his illness in strongly self-condemnatory terms, apparently quite failing to see it all as illness at all, when any of his friends etc., quite easily recognize that he is unwell.

Diagnosis

The pure obsessional illness is often hard to distinguish from a depressive illness with obsessional features since depression usually accompanies the former. The history, however, should be helpful.

Schizophrenia may present as an obsessional illness, or obsessional features may complicate it. This can present a tricky diagnostic problem. Obsessions associated with schizophrenia tend to be rather bizarre.

Treatment

1. PSYCHOTHERAPY

Analytic psychotherapy of obsessional illness aims at discovering the symbolic meaning of the phenomena, for the psychoanalytic view of obsessional illness is that it results from overactivity of the superego which defends the ego against overwhelming anxiety by magical rituals. In practice obsessionals do not respond particularly well to psychotherapy, their pedantry and excessive concern with detail cause them to become enmeshed in the therapeutic process and brought to a halt.

Supportive therapy however can help the patient to ventilate pent up feelings about his rituals and afford him some relief of anxiety and tension.

2. MEDICATION

(a) Tranquillizers can be useful in reducing anxiety. The most useful is librium which should be administered to the limit of tolerance.

(b) Antidepressive drugs should always be tried whenever there is any evidence of depression.

3. PHYSICAL TREATMENT

(a) E.C.T. is useful in the presence of depression.

(b) Leucotomy is used in the treatment of chronic severe obsessional disorder accompanied by persistent tension and misery.

Natural History and Prognosis

Obsessional illnesses show phases of remission and exacerbation (Pollitt 1960) so that the long term outlook is not so gloomy as is sometimes feared. Nevertheless the illness can be crippling. It is useful to use social criteria in assessing the degree of handicap e.g. one should try and find out how long per day the patient spends on his rituals; do they prevent him from working or is he late for work etc?

The presence of depression of any degree makes the outlook better.

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CHAPTER 8

Alcoholism and Drug Addiction

ACUTE ALCOHOLISM

This is a condition which is commonly encountered in medical practice. Acute alcoholic intoxication is a familiar sight and is adequately described in medical textbooks. It can be a fatal condition particularly when it is misdiagnosed in the presence of closed or open head injury.

CHRONIC ALCOHOLISM AND ALCOHOL ADDICTION

Chronic alcholism is a state in which a patient becomes dependent on alcohol to such a degree that it interferes with his physical and psychological health and impairs his professional ability and social relations. It includes alcoholic addiction which is really only an exaggeration of it, the only difference being that the addict drinks increasing quantities and is more likely to develop physical and psychological symptoms on withdrawal from alcohol. Also he craves it.

It is important to emphasize that there is a difference between addiction and chronic alcoholism. All addicts are alcoholics but not all alcoholics are addicts. Addiction is easily diagnosed. Chronic alcoholism is not.

Incidence

The incidence of chronic alcoholism is hard to estimate. A conservative estimate puts the figure at 500,000 in the United Kingdom.

The importance of the recognition of chronic alcoholism lies in the fact that it is a destructive process. It destroys health, personal relationships, professional life and prospects, and unchecked, leads to disaster.

Infection, Exhaustion & Toxic Psychoses.

Aetiology

Not precisely known though family studies of alcoholics show a high loading of psychosis and personality disorder. The simplest view of aetiology acknowledges no specific agent but would take into consideration first of all the *symptomatic alcoholic,* i.e. an individual who resorts to alcohol in the course of an illness such as depression or schizophrenia. Such patients account for less than 10% of chronic alcoholics.

Alcoholism may be a feature of personality disorder admittedly but the bulk of alcoholics do not fall into a homogeneous group no matter how they are studied. Commonly the alcoholic becomes such from a combination of factors—he may drink to relieve neurotic anxiety, or to escape from his difficult life situation. Certain occupations present a significant risk of alcoholism e.g. barmen, commercial travellers.

Manifestations

INTRODUCTION

There is a pattern in the history of chronic alcoholism which at least can aid in the diagnosis. The following are found to be signs that drinking is getting out of control:

gulping,
taking extra drinks before parties,
drinking on the way home,
drinking during the day,
lying about one's consumption of alcohol,
avoiding the topic of alcohol in conversation,
concealing alcohol on the person,
carrying drink to work,
taking 'liveners' on rising,
amnesic gaps.

The incipient alcoholic passes through a stage of habitual excessive drinking bouts till he is drinking all the time.

The full blown clinical picture may be easily recognized by the familiar picture of the red-faced, obese, probably bronchitic, toper, moving from saloon bar joviality to maudlin tears or uncontrolled anger with easy rapidity.

Physical complications of chronic alcoholism include:

nausea,
gastritis,
diarrhoea,

hepatic cirrhosis, liver failure, portal systemic encephalopathy,
piles,
pancreatitis,
bronchitis,
pulmonary tuberculosis,
peripheral neuritis.

PSYCHOLOGICAL MANIFESTATIONS

Apart from the psychological changes already described there are certain complicating syndromes, namely:

Alcoholic Hallucinosis

A condition characterized by auditory hallucinations of long standing followed by the development of paranoid delusions. It is controversial whether this is a syndrome in its own right or merely the incidence of schizophrenia in an alcoholic.

Typically the onset is insidious and remits if the patient abstains from alcohol.

Delirium Tremens

As the name implies this a state of restlessness and impaired consciousness associated with tremors. The onset usually follows alcoholic withdrawal and may be heralded by a twenty-four hour prodromal period in which apprehension is prominent, also misinterpretation of the environment, mild disorientation and fits.

The florid clinical picture reveals an excited hallucinated (visually and aurally) patient, misinterpreting his environment in paranoid fashion and in an affective state of terror.

He is usually restless and febrile.

Treatment. Nursing in a darkened room, the provision of plenty of fluid, vitamin saturation and the use of phenothiazine tranquillizers will restore to normal contact with reality in under 36 hours.

Korsakov's Psychosis

A syndrome of gross impairment of recent memory with a tendency to confabulate answers. This syndrome was originally described in alcoholics but can also be caused by arteriosclerosis etc.

Alcoholic Dementia

There is nothing particular about the condition apart from the aetiology. An extremely insidious onset is the rule.

Treatment and Prevention of Alcoholism

The first step in treatment is withdrawal from alcohol. This can only be achieved in hospital and the successful treatment of alcoholism depends on this initial step followed by absention. Withdrawal is not difficult to manage; it requires a degree of cooperation which reflects the patient's intention to get rid of the habit. And of course, the patient is under no compulsion to do this.

There is no point in prolonging the agony by giving diminishing quantities of alcohol, it is better to stop it completely and be prepared to treat any complications which follow e.g. fits or delirium tremens.

Sedatives such as barbiturates are best avoided in the withdrawal period; most workers prefer to use phenothiazine tranquillizers (Chlorpromazine, Promazine) to allay restlessness, combined with *vitamin saturation* and plenty of fluid and nourishment.

Once the withdrawal period is over one is faced with the problem of encouraging abstention from alcohol for the rest of the patient's life.

There are several ways of approaching this problem; none is complete in itself.

First, by medication, disulfiram (antabuse) provides a chemical defence against alcohol for the patient so that if he takes a drink when on regular antabuse medication, he gets an unpleasant reaction in which he feels unwell, flushes and collapses. The success of this treatment depends on the degree of cooperation that the patient is willing to offer.

The main forms of help offered to the alcoholic are psychotherapeutic and social.

Individual psychotherapy probably has little to offer the alcoholic but the available evidence suggests that group psychotherapy in specialized units has, by helping the alcoholic to see his difficulties in perspective, and to come to terms with the problems that drink provides for him, and the problems created for him by abstention. Not least it may show him the problems that force him to drink. A telling comment on this was made by a patient who said 'It's all very well asking me to give up drink but what are you going to put in its place?'

Alcoholics Anonymous (A.A.) plays a great part in the treament of the alcoholic and its help should be offered to all. It is an organization of alcholics devoted to helping each other to abstain from drink and has the great merit of being founded on common sense principles of a semi-religious sort.

The symptomatic alcoholic is treated by treating first of all the underlying condition.

Prognosis

Prognosis is not precise but a few general comments can be made.
The sounder the individual's personality the better the prognosis.
The shorter the duration of alcoholism the better.
Occupations leading to alcoholism make the prognosis worse (barmen etc.).

DRUG ADDICTION

Addiction though not apparently as common in the U.K. as in the U.S.A. and Scandanavia, is nevertheless of importance and its prevalence probably under-estimated by the Home Office.

The common drugs of addiction fall into two groups, *stimulant* and *sedative* drugs.

Sedative drugs include dangerous drugs of the morphia type.

Heroin and Morphia Addiction

The form of addiction with the gravest prognosis. The heroin addict usually takes drugs intravenously ('main line') and ultimately comes to depend entirely on heroin for all his pleasure in life, indeed almost all his sustenance so that he starves and wastes. This accounts for the inanition of the addict. He has no wish to eat, often no money for food, only for the drug.

There are no *specific physical* signs of addiction *per se* bar the signs of *morphia intoxication* described in pharmacology textbooks. Injection scars are found in the ante cubital fossae and forearms.

Altered mental states are seen in withdrawal; commonly they are states of excitement and hallucinosis.

TREATMENT

First withdrawal, covered by vitamins, fluids, food and tranquillizers and then *encouragement of abstention*—unhappily an extremely difficult task, utilizing psychotherapy and social agencies.

Barbiturate Addiction

Barbiturates are overprescribed hence chronic barbiturate intoxication and addiction may arise more frequently than is suspected. In *chronic barbiturate intoxication* are found slurred speech, nystagmus and ataxia with varying states of confusion. Withdrawal from barbiturates often produces fits and the withdrawal period should be covered in the way already described for alcohol and morphia.

Stimulant Drugs

The commonest in use are those of the amphetamine type including dexedrine, drinamyl, amphetamine and preludin. These drugs, taken by people of normal and abnormal personality for their stimulant effect produce a short-lived feeling of wellbeing followed by gloom inducing the taker to consume larger quantities of the drug so that up to 2 g per 24 h may be consumed.

States of *restlessness and irritability* with outbursts of anger are common but probably the most serious manifestation is *amphetamine psychosis* (Connell 1954). This is a syndrome of restlessness, elation, paranoid ideas and hallucinosis i.e. a schizophreniform psychosis which clears up after withdrawal.

Treatment of amphetamine addiction is made the more difficult by its prevalence amongst psychopaths and by its unnecessary prescription. It is on the increase.

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CHAPTER 9

Subnormality

Individuals who have 'arrested or incomplete' mental development *from birth* are described as being *mentally subnormal*. Their basic defect is one of intelligence. This produces psychological and social handicaps of varying degree.

INTELLIGENCE

Intelligence defies precise definition. However a good working definition is that it is an innate ability which enables the individual to learn from experience, form judgements, handle concepts and modify behaviour. It is not regarded as something fixed but as something modifiable by environment, i.e. by education and favourable upbringing. Also it is apparent that the extent to which people utilize their intelligence is influenced by their level of motivation, emotional stability and maturity.

Experimental evidence shows too that intelligence is *multi-factorial*—that is to say a general level of ability subsumes certain special abilities all of which correlate highly with each other.

Measurement of Intelligence

Tests have been devised, these are tests of ability. They are *standardized* for *large populations* and are *reliable* (i.e. when repeated on the same person give the same answer) and *valid* (i.e. measure what they are meant to measure).

INTELLIGENCE QUOTIENT (I.Q.)

This is a numerical way of expressing the level of intelligence. Originally the I.Q. was estimated by the calculation

$$\frac{\text{Mental Age}}{\text{Chronological age}} \times 100$$

since the first attempts to measure intelligence (Binet) took as their unit of measurement the *mental age* i.e. the average level of ability that could be predicted for given age groups. It will be realized therefore that to a large extent the I.Q. may be an unreliable figure.

At the present time the *measurement of intelligence* is based on the assumption that the *mean I.Q. is 100* and calculating the *deviation from the mean*. In this way individuals are allotted a *percentile score* i.e. the score is in the range that a certain percentage of the population will score on the same test. This sort of approach provides a more accurate and meaningful estimate of intelligence. The intelligence levels of the general population when plotted follow a general curve of *normal distribution*.

Subnormality is said to exist when the I.Q. is *below 70* and *severe subnormality* when the I.Q. is *below 55*.

SUBNORMALITY

Clinical Types

The bulk of subnormal patients are statistical deviants i.e. lie at the lower end of a normal frequency distribution curve. They tend to have a *dysplastic appearance* and have smaller cerebral measurements than the population at large. Their brains are smaller and their general health poorer. Apart from emotional instability and immaturity their greatest handicaps are social. The *subnormal* patient can just about look after himself under supervision but cannot survive in the outside world except in sheltered surroundings (in the words of the Mental Health Act 'requires or is susceptible to special training'). The *severely subnormal* cannot guard himself against common dangers, those of lowest I.Q. requiring even feeding etc.

Aetiology

1. Birth trauma 2. Neonatal cerebral infection	} account for only a small proportion.

There are however, a number of *pathological variants* at the lower end of the scale i.e. *special syndromes* associated with subnormality. They include:

1. Down's Syndrome (Mongolism)

So called because of the supposed (mistaken) resemblance to the Mongolian race. The incidence is about 1 in 650 births.

MANIFESTATIONS
(a) broad nose,
(b) flattening of the head,
(c) large tongue,
(d) oblique eyelids,
(e) short fingers associated with
(f) congenital heart lesions.

AETIOLOGY
(a) Increased maternal age.
(b) Chromosomal abnormality: there being 47 chromosomes, the extra one being at 21, hence the name *Trisomy 21*.

2. Cretinism

MANIFESTATIONS
(a) Lethargy and slowness,
(b) characteristic cry,
(c) puffiness of face, hands and neck,
(d) subnormal body temperature.

TREATMENT

Thyroid ½ gr per day up to a maximum of 5 gr daily.

3. Turner's Syndrome

MANIFESTATIONS
(a) Subnormality,
(b) ovarian dysgenesis,
(c) dwarfism,
(d) webbing of the neck,
(e) coarctation of aorta.

AETIOLOGY
45 chromosomes.
XO chromosomal constitution.

4. Kleinfelter's Syndrome

MANIFESTATIONS
(a) Subnormality (usually slight),
(b) small testes and aspermia,
(c) gynecomastia.

AETIOLOGY
47 chromosomes.
XXY chromosomal constitution.

5. Tay Sachs Disease

MANIFESTATIONS
(a) Subnormality,
(b) blindness (macular degeneration) → 'cherry red spot' at the macula.
(c) spasticity.

AETIOLOGY
(a) Simple recessive inheritance.

6. Epiloia (Tuberose Sclerosis)

MANIFESTATIONS
(a) Epilepsy,
(b) subnormality,
(c) tumours of lung, heart, brain, eye, kidneys, liver, spleen,
(d) skin lesions: adenoma sebaceum.

AETIOLOGY
Simple dominant inheritance.

7. Phenylpyruvic oligophrenia

MANIFESTATIONS
(a) Subnormality, often severe subnormality,
(b) behaviour disorders,
(c) fair skin, blond hair, blue eyes,
(d) epilepsy.

AETIOLOGY
Inborn metabolic error carried by a single recessive gene. The incidence is about 1 in 25,000 births.

The error inhibits the oxidation rate of phenylalanine to tyrosine thus causing phenylalanine to accumulate in the body and be excreted in the urine.

Treatment has been achieved by putting affected individuals on a diet low in phenylalanine.

8. Hartnup disease

MANIFESTATIONS

(a) Renal aminoaciduria,
(b) pellaginious skin rashes,
(c) cerebellar ataxia,
(d) subnormality.

AETIOLOGY

(a) Single recessive genetic inheritance,
(b) defect of renal tubular reabsorption,
(c) block in tryptophan metabolism.

9. Maple Sugar disease

MANIFESTATIONS

(a) Urine smelling of maple sugar contains amino acids,
(b) subnormality.

AETIOLOGY

(a) Disordered metabolism of branched chain aliphatic amino acids,
(b) single recessive genetic inheritance.

10. Laurence Moon Biedl Syndrome

MANIFESTATIONS

(a) Obesity,
(b) hypogonadism,
(c) diabetes insipidus,
(d) polydactyly,
(e) pigmented retinitis.

AETIOLOGY

(a) Hypopituitarism, possibly of genetic origin.

Treatment of the Subnormal Patient

Severely subnormal patients usually require hospital care throughout their lives as the burden of looking after them is something that can only be carried in special units.

Subnormal patients may need full investigation in hospital in order to:

(a) estimate their level of handicap,
(b) estimate their level of educability,
(c) treat associated disorder, e.g. epilepsy.

It has been found that subnormal patients are capable of learning tasks previously supposed to be beyond their ability providing the teaching is carried out in a particular way. For instance tasks need to be broken down into steps which are learnt one at a time. And the patient needs to learn via one sensory channel rather than being given a variety of instruction all at the same time. Also the subnormal patient needs a special climate where repeated failure is not penalized and where his emotional outbursts can be accepted.

The *family* of the subnormal child need support as well as social guidance, since parents often feel very guilty about having their child in hospital and their own inability to cope with him.

CHAPTER 10

Psychiatry and the Law

THE MENTAL HEALTH ACT, 1959

Historical Background

The history of the care of the mentally ill is on the whole a grim story consisting mainly of neglect, indifference and ill treatment, despite islands of progress. From time to time reforming persons halted this process and laws were passed to regulate the running of asylums for the insane and protect the inmates.

The main purpose of such institutions was custodial— if a patient entered, he stood only a small chance of returning to the world since little active treatment could be offered and society did not welcome his return, believing him to be dangerous and beyond hope of improvement.

The nineteenth century saw emphasis on *the moral treatment of the insane* i.e. treating patients like human beings, and a great deal was accomplished to improve the care of patients, finding them useful occupations, removing restraint and encouraging a more hopeful attitude.

Nevertheless legislation was cumbersome, and even as late as 1890 the passage of the Lunacy Acts did not make the position easier. If anything the mental hospitals were fixed in a custodial role, since voluntary admission to mental hospital was impossible. A step forward occurred in 1930, with the Mental Treatment Act, which enabled people to enter hospital voluntarily. In the past twenty years, as knowledge and therapeutic zeal increased, it became apparent that a less unwieldy set of laws was needed. This culminated in 1959 with the *Mental Health Act*.

The Act itself

This is a comprehensive act which repeals the Lunacy Acts of

1890 and the Mental Treatment Act of 1930. The most important general features are as follows:

1. Control of mental hospitals and mental nursing homes etc., passes from the *Board of Control* to the *Ministry of Health.*
2. Informal admission of patients is encouraged.
3. The procedure surrounding compulsory admission to hospital is made more clinical and less formal and intimidating.
4. The role of the local authority in mental health services is defined.

The act is divided into nine parts.

Part 1 repeals previous legislation, defines and classifies mental disorder and proclaims informal admission,	(Sec, 1–5)
Part 2 deals with the role of the local authority	(Sec. 6–13)
Part 3 deals with nursing homes etc.	(Sec. 14–24)
Part 4 deals with compulsory admission to hospital	(Sec. 25–59)
Part 5 deals with criminal patients	(Sec. 60–80)
Part 6 deals with transfer of patients	(Sec. 81–96)
Part 7 deals with special hospitals (for dangerous and violent patients)	(Sec. 97–99)
Part 8 deals with management of property and affairs of patients.	(Sec. 100–121)
Part 9 Miscellaneous	(Sec. 122–154)

The sections of the Act of most interest to students are sections 25, 26, 29 and 30.

SECTION 25

Under this section of the Act it is possible to detain a patient in a mental hospital for a period not exceeding 28 days, for the purpose of observation. A medical recommendation to this effect is signed by two doctors—

(1) the patient's own doctor (where possible),

(2) a doctor recognized by the Act as having special experience in psychiatry.

The application for admission is made by the nearest relative, or if not available a mental Welfare Officer.

SECTION 26

Is the section under which an order for *treatment* is made, on the grounds that the patient is a danger to himself or others or is not suitable for informal admission. This is valid for 1 yr. The patient has the right of appeal against this after 6 months to a review tribunal.

SECTION 29

Provides a means of *emergency admission*. It permits the patient to be detained for 72 h. pending conversion to either S.25 or informal status.

The application is made by the nearest relative or Mental Welfare Officer, and the medical recommendation is made by any registered practitioner providing he has seen the patient within 24 h. of signing.

SECTION 30

Provides for retention in hospital of a patient already in, who becomes ill and requires compulsory observation. This order, signed by the doctor in charge of the patient, authorizes his being kept in hospital for 72 h. pending further action.

Criminal Responsibility

It is an established principle of English Law that a man is responsible for his own actions—that is to say that he intends their result. Therefore it follows that in the eyes of the law he must bear the responsibility for them. In the case of capital offences, responsibility is the more likely to be questioned. In the case of an individual suffering from mental illness committing a crime, it has been for many years argued that the man's state of mind must impair his responsibility for his acts. This has, however, not been easy to establish in a court of law since the law assumes everyone is sane, and insanity has to be proven. Since 1843 the courts have used the MacNaughten Rules as a test of insanity. These rules arose following the trial for murder of Daniel MacNaughten who killed Sir Robert Peel's private secretary. MacNaughten had paranoid delusions and was acquitted on the direction of the judge.

Subsequently judges formulated the rules as they have been known ever since, as a series of answers to questions put to them by the House of Lords. In practice the rules seek the answers to the questions:

(1) Regarding the offence; did the accused know the nature and quality of the act?

(2) If he did, did he know he was doing wrong?

(3) If he knew the nature and quality of the act, was he labouring under a delusion?

Despite their apparent simplicity, the rules can be difficult to apply and make for only a limited acknowledgement of impaired responsibility. For years they have been the subject of controversy, both here and in the United States. Nevertheless they are still widely applied as tests of insanity in capital cases.

Since the Homicide Act of 1957 the Law in England and Wales has acknowledged the concept of diminished responsibility, which can be invoked if an accused person is shown to be suffering from 'such abnormality of mind . . . as substantially to impair his responsibility'. The concept of diminished responsibility has not been accepted without reserve, and it has been pointed out that once allowance is made for diminished responsibility one is calling into question the whole idea of criminal responsibility at any level.

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CHAPTER 11

Treatment in Psychiatry

The term 'Treatment' is used in a wide sense in psychiatry; specific remedies for illnesses of known aetiology are practically unknown, so treatment tends to be empirical and eclectic. Treatment therefore includes any measures used:

(a) to influence the patient's mental state, and

(b) to assist in his rehabilitation and return to the community.

The measures used comprise the following groups:

(a) psychological	psychotherapy behaviour therapy	used to deal with individual's symptoms, illness and personality
(b) physical	pharmacologic agents e.g. sedatives tranquillizers antidepressive drugs	used in acute psychoses, depressive illness and 'maintenance' treatment of chronic illness
(c) occupational	occupational therapy	used to divert, stimulate entertain and encourage the patient's activity and interest
	industrial therapy	plays an important part in rehabilitation by giving the patient the chance to work and earn in a sheltered environment

Certain measures may be of most value in the acute illness, e.g. physical treatment; others may be of most value in rehabilitation, e.g. industrial therapy. Patients should receive help in as many ways as possible. The acute illness may be controlled by tranquillizers which restore the patient's contact with reality and enable him to participate more successfully in psychotherapy, and derive some benefit from a therapeutic environment. Providing the environment is permissive and friendly, it is therapeutic rather than antitherapeutic. Social forces too, are important in colouring illness and adding features which are neither symptoms or signs of illness but merely behaviour patterns imposed by the environment. Violent behaviour has become less common since this was realized. The struggling patient brought into hospital and hurled into a padded room, isolated in total darkness, would be less than normal if he did not react in hostile fashion towards his surroundings.

It is important to realize that any hospital admission provokes anxiety mainly because of the uncertainty that the patient experiences and also because he feels his individuality threatened right from the beginning by simple things like having to undress and get into bed. After this, much that goes on in hospital seems to reinforce the feeling of isolation and lack of identity so that if the atmosphere is worsened by heightened uncertainty, tension and suppressed violence—all of which can be commonplace in a badly run psychiatric ward—one soon has all the ingredients for a situation of the sort which Kafka has described in such frightening fashion.

PSYCHOLOGICAL TREATMENT

1. Individual Psychotherapy

Psychotherapy is treatment based on verbal communication between patient and doctor and the formation of a therapeutic relationship between them.

The simplest form, and the most widely practised is *supportive psychotherapy*, in which the patient is encouraged to talk freely about himself and his symptoms and problems without exploring his unconscious mental life. No attempt is made to give the patient insight about the possible origins of his difficulties. His defences are shored up rather than broken down.

Psychoanalysis is the most important type of analytic psychotherapy. The term 'psychoanalysis' is used in two main ways, first it refers to a form of psychotherapy, and secondly it gives the name to the school of psychology founded by S. Freud.

Psychoanalytic theory is a theory of personality structure and development which stresses the fundamental importance of childhood experience in forming the personality. Freud based his theory on observations made on patients he had treated. Classical Freudian theory has been modified by his followers but the central hypothesis is that human behaviour is determined predominantly by unconscious forces and motives springing from primitive emotional needs.

In psychoanalysis the analyst seeks to explore and modify the personality structure of the patient by intensive and prolonged exploration of this unconscious mental life. This is achieved by use of the technique of *free association*. The patient lies on a couch and allows his thoughts to wander in any direction—in this way dredging up unconscious material of which he has previously apparently been quite unaware. The reason for getting the patient to lie down is so as to cut down to a minimum visual stimuli which might distract. The analyst interprets to the patient the symbolic meaning of his dreams and fantasies helping him towards insight about himself. It is necessarily a prolonged and time consuming process.

Analytic psychotherapy short of full scale psychoanalysis, is commoner and less cumbersome a process, and tends to be concerned with more clearly defined goals such as:

(a) resolution of conflict,

(b) working through problems and viewing them in a different light,

(c) the relief of pent up feelings.

The relationship between doctor and patient in psychotherapy is of paramount importance. Much of the content of interviews is so to speak 'hot material' and the patient soon invests the therapist with a good deal of feeling. Feelings of dependence, love, affection and hostility are common and the therapist has to know how to handle them and how to interpret their meaning to the patient. A personal analysis provides the only training for the psychoanalyst.

A non-analytic psychotherapist gains a great deal from a personal analysis but if this is not possible the good psychotherapist needs to be intelligent, intuitive, patient and above all, flexible.

2. Group Psychotherapy

In group therapy the main focus of interest is on the interrelationships within the group, rather than on the highly personal relationship as in individual therapy. Problems are shared in the group situation, and patients are able to see their own difficulties in interpersonal relationships reflected in the group, and so in a different light. Also they are subject to criticism, encouragement and support from other members of the group.

In practice groups should be small—about twelve members being the ideal number. It is found useful to select members of similar ages and with equal division of sexes. The therapist sits with the group—topics are discussed freely, the therapist adopts a non-directive role, avoiding domination or direction of the group but preventing them straying into defensive irrelevancies.

3. Abreaction

Is the name given to a therapeutic process in which a patient relives an important past experience which has contributed significantly to the development of his illness. The re-enactment is accompanied by discharge of pent-up feeling. Freud found this happening to his patients, particularly under hypnosis, and he reasoned that it would be valuable to induce such states so that the patient would benefit by the emotional discharge. The technique of abreaction is used mainly in acute conversion hysteria precipitated by traumatic events, e.g. wartime disasters. Various methods other than hypnosis have been used to bring about a state of altered consciousness conducive to abreaction. The most widely used is the slow intravenous injection of a 5 per cent solution of sodium amytal.

4. Behaviour Therapy

Is the general name given to a relatively recent form of psychological treatment. Behaviour therapy has its roots in behaviouristic psychology as opposed to psychotherapy which is founded on dynamic psychology.

Behaviouristic psychology explains human behaviour in terms of stimulus—response mechanisms. Behaviour is regarded as learnt by Pavlovian conditioning processes governed by such processes as drive reduction. Thus neurotic behaviour is simply explained in terms of maladaptive behaviour rather than being linked with complicated intra personal, emotional development.

It follows from this view of neurotic illness that if the neurotic symptom is removed, the illness disappears too—an entirely opposite view to the psychodynamic one which sees symptoms as symbolic representations of internal conflict. A behaviouristic explanation of a phobic anxiety state would be that the patient has become conditioned to experience anxiety whenever he perceives certain signals and that this conditioned response has gradually generalized so that it is triggered off by a wide variety of signals.

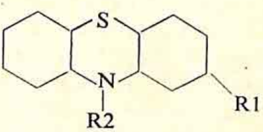
Behaviour therapy seeks to eradicate the maladaptive response by a process of desensitization. Wolpe has pointed out that the anxiety response can be inhibited by placing the individual in situations resembling those which provoke anxiety but which are sufficiently unlike them not to trigger off any anxiety. This builds up a generalizing process of reciprocal inhibition of anxiety, which is reinforced by rewards in the form of further anxiety-free situations.

PHYSICAL TREATMENT

Nowhere is empiricism more evident than in the sphere of physical treatment in psychiatry. Methods have appeared; a remarkable array of drugs is on the market; all are greeted with initial uncritical enthusiasm and later more soberly evaluated. The whole question of the use of physical treatments has aroused strong feelings on both sides. Nevertheless it is a fact that certain physical treatments have established themselves as important therapies which have revolutionized psychiatry.

1. Tranquillizers

Tranquillizers are drugs which alter behaviour without impairing consciousness. Their place in psychiatry dates from 1953 when the tranquillizing effects of *Chlorpromazine* were first demonstrated. *Chlorpromazine* was the first of the phenothiazines to come into use, and the majority of the tranquillizers in present use belong to the phenothiazine series. Phenothiazines all have the basic structure:



where R1 and/or R2 are side chains varying from one phenothiazine to another

Chlorpromazine (Largactil) is most useful in calming psychotic excitement whether organic, affective or schizophrenic in origin. It is widely used in the maintenance treatment of chronic psychotic patients but the usefulness here is much less certain. It can be administered by either the intra muscular or oral route. *Dosage* is up to a maximum of 1000 mg per day in divided doses, though a maximum of 600 mg per day is rarely exceeded.

The most serious *side effects* include anaemia, agranulocytosis and jaundice. Less important effects include hypotensive attacks, photosensitivity and dermatitis.

Chlorpromazine potentiates the action of barbiturates, alcohol, anaesthetics and narcotic drugs.

Promazine (Sparine) is a phenothiazine of similar structure and action though probably less powerful weight for weight than chlorpromazine. Side effects such as rashes and hypotension may be less than with chlorpromazine.

Thioridazine (Melleril) has a similar dosage range to Chlorpromazine, and similar actions.

Trifluoperazine (Stelazine) is an important drug of the prochlorperazine series (derived from the phenothiazines). It is said to have an alerting and antihallucinogenic effect in contrast to the sedative effect of the other phenothiazines. It is widely used in the treatment of both acute and chronic schizophrenic patients. It can be administered parenterally or orally. *Dosage* ranges from 5–40 mg per day in divided doses. There is evidence to suggest that in small doses (2 mg t.d.s.) it is useful in the treatment of chronic anxiety states.

Side Effects

The most common are neurological syndromes affecting the extrapyramidal pathways:

(1) motor restlessness (akathisia)
(2) facial rigidity } Parkinsonian syndrome
(3) stiffness of limbs
(4) persistent tongue protrusion
(5) dystonic movements of the head and neck

These neurological side effects can be well controlled by use of antiparkinsonian drugs such as Orphenadrine (Disipal) etc.

2. Antidepressive drugs

Drugs used in the treatment of depression fall into two main groups:

(a) Monoamine oxidase inhibitors.
(b) Imino dibenzyl derivatives.

The first drugs used in the treatment of depression were *ampheta-*

mine and its derivatives. They had the advantage of cheapness and a lack of minor side effects. Unfortunately the dangers of addiction have made their use in depression less desirable. Also they are not effective in severe depression.

(a) MONO-AMINE OXIDASE INHIBITORS (MAO INHIBITORS)
The first demonstration of the euphoriant effect of this group of drugs was the observation that INAH used in treatment of tuberculosis made patients euphoric. Since then a large number of MAO inhibitors have been developed, the most commonly used at the present time being—

Isocarboxazid (Marplan) Dosage range 10–30 mg t.d.s.
Phenelzine (Nardil) Dosage range 15–30 mg t.d.s.
Tranylcypromine (Parnate) Dosage range 15 mg t.d.s. to 15 mg q.d.s.

Side Effects
MAO inhibitors potentiate the action of barbiturates, pethidine and morphia derivatives, and should be withheld from anyone receiving an anaesthetic for 10 days beforehand because of the danger of *hypotensive crises*. Tranylcypromine has been shown to cause severe headache and collapse, particularly when the subject eats cheese or Marmite. Patients on this medication should be warned of this. Liver damage has been ascribed to various MAO inhibitors but none of the three described have so far been incriminated. Other common minor reversible side effects include oedema, sexual impotence and failure of orgasm.

(b) IMINO DIBENZYL DERIVATIVES
The two important drugs of this kind are:

Imipramine (Tofranil)
Amitryptiline (Tryptizole)

Imipramine is chemically similar to Chlorpromazine and has been used in treatment of depression since 1959.

Dosage range 25–75 t.d.s.

Side effects include dryness of the mouth, blurring of vision, wakefulness, constipation, states of excitement and hypotensive attacks.

Amitryptiline is given in a dosage range of 25–75 mg t.d.s. Side effects include dryness of mouth, blurred vision, constipation and states of excitement.

These drugs should not be given in combination with MAO inhibitors.

GENERAL OBSERVATIONS ON THE USE OF ANTI-DEPRESSIVE DRUGS
Though they are widely prescribed, there is by no means universal agreement either as to their efficacy or mode of action. Controlled trials have revealed conflicting results. On the one hand there are those workers who are convinced that antidepressive drugs exert a specific effect on the supposed depressive process, whilst on the other there are those who claim that the drugs act merely by their sedative effect on agitation and anxiety. It has been pointed out that depression has a high rate of natural remission and that the enthusiasm for the effects of antidepressive drugs may be accounted for by this alone. Whatever the facts may turn out to be, one thing seems certain and that is that physicians have become more alerted to depression and its existence as a condition meriting attention and treatment.

3. Drugs used in the treatment of anxiety

Apart from short acting barbiturates which are widely used, there are two tranquillizers in common use. They are:

Meprobamate (Equanil) 400–800 mg t.d.s.
Chlordiazepoxide (Librium) 10–40 mg t.d.s.

4. Vitamins

Large doses of vitamins of the B group are used routinely:

(a) in the treatment of delirium tremens,
(b) in the treatment of subacute delirious states.

5. Insulin is used:

(a) as an appetizer
(b) in modified Insulin Treatment. This is a form of treatment used in states of anxiety. The patient is given increasing doses of soluble insulin in the morning with the object of producing a drowsy relaxed state and inducing hunger. The treatment is terminated by a large carbohydrate meal.

6. Electro-convulsive Therapy

Of all physical treatments E.C.T. is apparently the most successful, yet its mode of action is unknown and in some quarters its use is viewed with suspicion. Speculative theories of a neurophysiologic sort suggest that the convulsion alters the conditionability of an intricate system or that in some way it alters the level of arousal of the central nervous system. Other theorists suggest that in some unknown way it alters the balance of a central mood regulating mechanism. These tend to represent the views of those favouring its use.

Those who are on the whole opposed to its use tend to suggest that it is a form of 'shock' treatment which in a way 'shocks' the patient into altered behaviour as in the past patients were 'shocked' by sudden immersion or being whirled around in revolving chairs. It has also been suggested that it is the sudden loss of consciousness which affects the patient. Nevertheless there is more uniformity of agreement about its usefulness than is the case with drugs.

ORIGINS

It was first used in 1938 by Cerletti and Bini. It had previously been incorrectly supposed that there was a negative correlation between epilepsy and schizophrenia and on the basis of this it was suggested that schizophrenia might be treated by convulsions. Meduna started by using chemically induced convulsions in 1935, while Cerletti and Bini were the first to use electrically induced fits.

The results in treating depression were soon shown to be successful. Depressive mood and agitation were replaced by normal mood within days of starting treatment, and it is in the treatment of depression that E.C.T. has an established place. It is successful in approximately 85 per cent of cases of depression. Whether or not it prevents recurrences is questionable but it does shorten the illness.

Its place in the treatment of schizophrenia is controversial, though most experienced workers suggest that it should always be tried. Acute schizophrenic episodes and schizo-affective illnesses respond best to it.

TECHNIQUE

The machine delivers a 200 v A.C. discharge for 1 sec. This induces instant loss of consciousness followed by convulsion. Nowadays it is usual to give modified E.C.T. and the practice is to modify it by using intravenous anaesthesia (Thiopentone 200–250 mg in a 5 per cent solution) with a muscle relaxant (Scoline or Brevidil) to prevent injury by violent muscular contractions. Oxygen is used to ventilate the patient, and the convulsion is induced. Recovery of consciousness is rapid e.g. within 10 min., and discomfort is no more than a pin prick in the arm. Atropine 1/75 gr is given intravenously with the Thiopentone.

Treatment is given twice weekly and the patient assessed between treatments. A course of treatment is not prescribed; it is preferable to stop when the patient is better. One should rarely give more than twelve treatments.

HAZARDS OF E.C.T.

These are:

Major

1. Normal anaesthetic hazards.
2. Special cardiovascular hazard, e.g. induction of cardiac arrhythmia.
3. Injury to tongue,
   teeth
   bones—longbones
   —scapula
   —crush fractures of vertebral bodies.

Minor

4. amenorrhea
5. headache
6. burns
7. memory loss
8. confusional states.

7. Leucotomy

The various types of leucotomy operation are all aimed at the relief of persistent tension. This is achieved by dividing connections between the frontal lobes and the Thalamus. The operation probably shows the best results when the tension arises in depressive states but it has also been used in obsessional disorder and in chronic schizophrenia.

The operation is now less widely performed since the advent of the tranquillizers and since its dangers have been more fully appreciated, nevertheless in carefully selected cases it continues to be used in the relief of chronic tension states.

OCCUPATIONAL

1. Occupational Therapy

For many years it has been realized that work can be a source of diversion to the disturbed patient. Nowadays the Occupational Therapist has a wide range of activities to offer the psychiatric patient. These include art and craft work which can calm the anxious patient or revive the interest of the retarded depressive. Tasks can be provided for the brain damaged patient which may afford him some degree of satisfaction.

Also the Occupational Therapist can assess the limits of such a patient's ability and help to provide him with a suitable environment. In rehabilitation the O.T. Department can help to plan a patient's daily round of activity to prepare for the return home by helping him to acquire new skills or refurbish old ones. The housewife can be particularly helped in this direction by the provision of a kitchen unit in the O.T. Department. Ideally Occupational Therapy should be realistic and diverse and as far removed as possible from the traditional picture of basket making or the manufacture of useless ornaments.

2. Industrial Therapy

This is an attempt to provide the patient with a working day, a regular wage and the prospects of working outside hospital.

It provides a sheltered working environment for the chronic patient where he can learn, practise and gain confidence in new skills.

In many hospitals light assembly work etc. is done on a contract basis with local firms and after a patient has 'proved himself', he can then go out to work.

Rehabilitation of chronic patients, particularly chronic schizophrenics, is a difficult task. Patients need graded tasks, much encouragement, careful assessment and supervision. In this the doctor is aided by many people including:

(1) nurses with special training and experience.
(2) social workers.
(3) psychologists.
(4) disablement resettlement officers.

SOCIAL MEASURES

The Psychiatric Social Worker

The P.S.W. occupies a central place in psychiatric practice bringing to it not only a knowledge of social factors and their importance in the aetiology of illness but also more sophisticated awareness of psychodynamics than that possessed by the non-psychiatric social worker. This is not to suggest that the P.S.W. should be some form of psychotherapist manqué since this would mean too limited a function. The work of the P.S.W. includes such diverse activities as:

(1) collection of data,

(2) highlighting of areas of social relevance in a patient's life situation,

(3) direct counselling about concrete social problems such as finance, housing, etc.

(4) social casework: this is a therapeutic technique in which the P.S.W. helps the patient to handle his problems and relate them to his social situation,

(5) helping a patient to get psychiatric advice,

(6) prophylaxis of psychiatric disorder,

(7) group discussions with the spouses of patients who have a common problem (e.g. alcoholics' wives),

(8) after care and follow up.

The Therapeutic Community

All hospitals are frightening places for the majority of patients, and mental hospitals are particularly so, since often they tend to be large, gaunt buildings with long anonymous corridors. In fact if one were to try and devise a way of making a patient worse one could hardly improve on traditional mental hospital custodial care, which tended to reduce patients to nameless lost creatures, with no identity. In fairness to those who worked in such conditions it should be pointed out that they did not have the advantages of the tranquillizing drugs of today nor enthusiastic support except from a few. It is also incorrect to suppose that 'open door' policies are a twentieth century phenomenon. They are really an extension of the best of English nineteenth century psychiatry. Unfortunately, as is often the case, pioneering ideas were forgotten and had to be rediscovered.

The moment anyone enters *any* hospital an attack is made on his existence as an individual—his clothes are removed and he is put to bed and he becomes another patient. In general hospitals this matters less since the duration of stay is short and the experience is soon forgotten. But for the psychiatric patient it can be disastrous, since he may be entering hospital for a long stay. Before the importance of social factors in influencing mental illness was generally appreciated, the object was to make the patient conform to a number of arbitrary behavioural standards often of a fairly absurd sort, as quickly as possible. Authority was hierarchical and not to be defied. This made tension increase and violence the more likely.

Patients soon learnt to survive by adapting themselves into numbed acquiescence with consequent loss of initiative and drive, so called 'institutional neurosis'. This was aided by isolation from visitors and lack of activity.

Belatedly it has been realized that the community in which the patient lives can have either a therapeutic or an anti-therapeutic effect and attempts are now made to produce a hospital environment which preserves the patient's individuality and stimulates him to activity and a return to the world outside.

Emphasis is laid on freeing the lines of communication between medical and nursing staff and encouraging free discussion between patients and staff, thus removing artificial and meaningless barriers. Of course running hospitals in this way means more work and more trouble as opposed to the apparent calm of a traditional 'well run' hospital supervised by a superintendent delegating authority downwards. It means more work, but less misery and more hope. Psychiatric patients need hope, noise, colour and activity. Too often their lives can be spent in a grey silence. Anyone who can prevent this is performing a therapeutic act.

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